Assessment of the Performance of

Small-Group Health Insurance Market Reforms in Maryland

As Required by Senate Bill 457/House Bill 695,
"Health Insurance—Study of Maryland's Small Group Market" (2001)

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The views expressed in the report are those of the author alone, as are any errors of omission or commission.

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Summary

In the 2001 legislative session, the Maryland legislature passed House Bill 695/Senate Bill 457, which required a study to compare the performance of Maryland's small-group health-insurance market reform law to that of other states. The fundamental question which this study is to address is this: Are there elements of Maryland's reforms that might be altered in a way that would improve access to affordable coverage—that is, to cause more small employers to offer coverage and more employees to accept it—without creating other adverse consequences? Special scrutiny is directed to the scope of benefits in the Standard Plan and to the reforms that limit insurers' ability to vary premiums based on the characteristics of small groups.

The study compares small-group reforms and performance in Maryland with six other states—New Jersey, Delaware, Virginia, North Carolina, Florida, and Colorado—and to the United States as a whole. The study uses data from a variety of sources: interviews with insurance agents and brokers, state regulatory officials, and health plans executives in all the study states; the Medical Expenditure Panel Survey, a national survey of the federal Agency for Healthcare Research and Quality; a special survey of state premium differences conducted for this study by the National Association of Health Underwriters; and research literature related to small-group market reforms and performance.

We assess the performance of Maryland's small group market in six areas:

Coverage rates for small groups. Maryland small establishments more often offer coverage than establishments in any of the other study states or in the U.S. as a whole. About 57 percent of Maryland employers with fewer than 50 employees offered coverage in 1999,[1] whereas the U.S. average was 47 percent, and in four of the study states fewer than half of the small employers offered coverage. So by this test, Maryland appears to perform well: coverage is more commonly available to employees of small firms than elsewhere.

Average cost of coverage. In 1999, average small-group premiums in Maryland for family coverage ($6,785) and single coverage ($2,735) were 11.9 percent and 10.3 percent higher than the U.S. average ($6,062 and $2,475 respectively), higher than in Virginia, North Carolina, Florida, and Colorado, but lower than in New Jersey and Delaware. By this measure of cost, Maryland's small group market seems to be slightly more expensive than average, but the higher cost does not seem to be associated in any obvious way with the nature of the small-group insurance reform differences among Maryland and other states.

Cost of coverage for common health benefits. The previous cost figures are simple averages, so they are not controlled for differences in benefits covered. A special study done for this project compared premiums in Maryland and the six study states for a common benefit package. The survey results indicate that the cost of coverage in Maryland for a group of average risk is somewhat lower than in most of the study states. The quotation for the fictional group was $3,247.09. Only North Carolina had lower-priced coverage ($3,016.17). The average for the five study states was $3,556.43, so Maryland's rate was about 9 percent below the average for the other states.

[1] Please see footnote 11 in the main report related to multiple sources of data.

Affordability. One reasonable way to measure affordability is to compare average premiums for all small employers in each state with the average pay of workers in the state. There are not major differences among the states by this measure of affordability. The range in the study states is from a low of 17.1 percent of pay for family coverage (Colorado) to a high of 20.7 percent (Delaware), with Maryland in the middle with 19.7 percent. The rankings for single coverage are similar.

Affordability could be considered to be affected by the way small employers and their employees share in the payment of the premium. Maryland employers contribute somewhat less toward the premium for single coverage and somewhat more to the premium for family coverage than is typical for the U.S. and most of the study states. This makes single coverage somewhat less affordable and family coverage somewhat more affordable in Maryland than elsewhere, other things being equal.

Premium trends. Another relevant measure of small-group market performance is the rate of increase of insurance premiums. The available data is limited to the period 1996 to 1999. During that period, premiums for both single and family coverage increased more rapidly in Maryland (27.0 percent and 24.0 percent respectively) than in the U.S. as a whole (19.6 percent and 22.8 percent) or than in the other study states except Colorado. The reasons for this difference are not clear but are not related in any obvious way to the rating reforms in place in the study states.

Degree of competition. Economists agree that vigorous competition among a number of competing firms in an industry is necessary for efficient markets. The number of competing health insurers and health plans has been decreasing rapidly across the country in the last decade or so, as major competitors merge and some companies disappear entirely. Maryland's experience has been similar to that of other states. Between 1995 and 1999, the number of insurers offering small-group coverage in Maryland declined from 37 to 23. If the market share controlled by a few competitors is used as a measure of competition, competition has declined. Between 1998 and 2000, the share of the two largest carriers jumped from 59 percent to 70 percent. Clearly, the number of health plans that can compete effectively across the state is not large, and the fact that just two firms control such a large market share diminishes competition. But it is unlikely that changes in Maryland's small-group reform laws could induce substantial numbers of additional carriers to enter the market or that changes would spread the business more equally among firms.

We asked the people we interviewed in Maryland for their assessment of how well the small-group market is performing and compared their assessment to those of the people we interviewed in other states. There was virtually unanimous agreement that Maryland's market reforms have had beneficial effects for small employers, making coverage more readily available and affordable for higher-risk groups and improving the basis on which competition takes place (that is, not competition to avoid high-risk groups). Some expressed mild support for relaxing elements of the rating rules, but no one expressed confidence that such a change would result in greatly increased coverage. There was widespread concern about the rapid increases in premiums in the last two years or so, but no one attributed this increase to small-group reforms. The cost escalation is a nation-wide phenomenon, and those we interviewed in every state expressed concern about it, regardless of the nature of their state's small-group market regulatory arrangements.

The study states vary widely in the nature of their rating reforms. Maryland and New Jersey have the most restrictive laws, with Virginia and Delaware having the least restrictive. In theory, rating restrictions should cause rates to fall for higher-risk groups, causing more to buy coverage, and should cause rates to rise for lower-risk groups, causing some of them to drop coverage. Most studies have not found strong effects from rating reforms. Generally, the total number of people covered does not seem to have been greatly affected. One recent study found that rates tended to be slightly higher (by 6 percent) in states with strong rating reforms, though these states do not seem to enroll a greater proportion of higher-risk employees.

An analysis of the benefits covered by the Standard Plans in the study states shows some

variation, but for the most part, Maryland's benefits do not seem to be far out of line with those offered in other states. Patient cost-sharing tends to be higher in Maryland, the mental health benefits and emergency room copayment amounts tend to be more generous, the prohibition against pre-existing condition limits is more generous, and the prescription drug co-payments are less generous for people who have HMO coverage but more generous for people with PPO coverage whose costs exceed the $250 deductible. (It is important to note that the Standard Plans account for an inconsequential portion of sales in the study states except New Jersey and Colorado. Thus, the comparison may not be particularly meaningful.) Nothing in our analysis leads us to suggest major changes in the coverage of the Standard Plan, although we do recommend a different approach to establishing benefits over time.

We turn next to a consideration of policy options, beginning with an important finding from research about the small-group market. There is strong evidence that small employers are not very responsive to price changes, so that it would take large reductions in premiums to induce significant numbers of uninsured small employers to buy coverage. To achieve a significant increase in the number of newly insured workers in the small-group market would require price changes significantly larger than would be produced by any changes in small-group market reforms that are likely to be made in Maryland.

A review of the operation of the Standard Plan in Maryland leads us to conclude that it continues to serve a useful purpose. It allows employers to have some confidence that the plan they are buying includes adequate benefits. Since the benefits are standardized, employers can compare insurers on just price and service level differences, a manageable calculation. The extension of the argument is that, knowing that customers can compare carriers for value differences, the competitive pressures on carriers to provide good value is greatly increased, thereby encouraging greater efficiency and higher levels of service. We believe that the function of fostering appropriate competition could be better served, however, by several modest changes:

Recommendation 1

We recommend that the Maryland Insurance Administration, in consultation with the Health Care Commission, take actions to ensure that the Standard Plan price comparisons (published as the "rate guide") are more understandable, useful, and widely publicized. Consideration should be given to changing the form in which the premium quotations are submitted and the way they are summarized in the public presentation to make the information simpler, more meaningful, and more accessible. To increase visibility of the information, at a minimum the Maryland Insurance Administration should issue a press release at the time of publication and make certain that key health and consumer reporters have the opportunity to talk to relevant public officials regarding the significance of the published price information.

Recommendation 2

We recommend that the Maryland Insurance Administration, in conjunction with the Health Care Commission, reconsider how to most effectively implement the requirement that insurers inform employers about the Standard Plan. The objective should be to determine what is the most effective way to ensure that insurers prepare and supply to potential customers information that includes a description of the purpose, function, and benefits of the Standard Plan, including the explanation that the benefits represent the Commission's judgment of the optimal mix of benefits given the budget constraint under which the Commission operates in establishing the benefits.

Another function of having the Standard Plan is to ensure that adequate coverage is available for a reasonable price. That is the purpose of requiring that the average premium not exceed 12 percent of the annual wage and requiring the Health Care Commission to change the covered benefits if that ceiling is exceeded. We believe that this practice is sound, but we recommend that the Commission use a somewhat altered approach when they reassess the benefits.

Recommendation 3

In determining the Standard Plan benefits, we recommend that the Commission use the approach that in public administration circles is referred to as "zero base budgeting." Instead of approaching the question of what to include in the Standard Plan benefits in an incremental way—that is, by deciding what should be added or subtracted from the present benefit package—we recommend that at least every five years, the Commission *start anew* and decide, without any preconceived judgments, what package of service benefits and cost sharing represents the optimum value given changes in medical technology, shifting relative costs, employers' actual buying patterns, consumer preferences, etc. In taking this approach, we recommend using 10 percent of the average wage as the budget constraint, which would leave some room both for future cost escalation (and thereby not require an immediate reconfiguration of the benefit package) and would allow employers to add "riders" and still keep the total average cost within the 12 percent limit (which, though not required by the legislation, has been the actual practice).

We also suggest that the Commission consider permitting employers to buy riders that would increase the cost-sharing provisions of broad categories of services. Such a change would give employers somewhat more flexibility and would be especially appropriate if the cost-sharing provisions of the Standard Plan were established to more closely match what employers typically choose.

With respect to Maryland's rating rules, we do not think that major changes are needed. The small-group market seems to be performing well. As noted earlier, no reasonable change is likely to cause premiums to fall sufficiently to induce large numbers of lower-risk employers to buy coverage, and making such a change could have a deleterious effect on higher-risk employers, causing them to bear significantly higher cost for coverage.

Recommendation 4

With one exception related to so-called "groups of one," we recommend that Maryland not change its rating rules that limit insurers' ability to vary premiums based on a group's characteristics.

We do believe, however, that changes are desirable for so-called "groups of one," essentially the self-employed. The present regulations encourage people in such groups to wait to buy coverage until they know they will need expensive medical care—a violation of the basic insurance principle. Allowing such behavior forces those who do not delay buying insurance until it is needed to bear more than their fair share of the premium burden. We thus recommend the following changes:

Recommendation 5

With respect to so-called "groups of one" (essentially the self-employed), we recommend that the present open enrollment policy be changed so that insurers offer open enrollment to these groups only once per year rather than twice per year.

Further, we recommend that one of the following two policies be adopted:

Option 1: **For groups of one *that have not maintained continuous coverage,* insurers and health plans would be permitted to base the first-year premium on medical underwriting (with the same rules that apply in the individual market). Once the group has been covered for one year, the rating rules for the group of one would be the same as those for other groups in the small-group market. Any group of one that has maintained continuous coverage (defined as having had coverage within the last 60 days) from any source would be rated in the first year (and thereafter as long as the business continued) with all small-groups; that is, they would not be medically underwritten. Further, groups of one that provide proof of continuous coverage when first applying for group coverage would not be required to wait for an open enrollment period to be eligible for group coverage and would not be required to show proof of income from self-employment.**

Option 2: **For groups of one *that have not maintained continuous coverage,* insurers and health plans would be permitted to apply to the first-year premium a surcharge specified by the Health Care Commission, for example, 20 percent. In the second year of con-**

tinuous coverage, the surcharge would be reduced to half that amount, for example, 10 percent. Once the group has been covered for two years, the rating rules for the group of one would be the same as those for other groups in the small-group market. However, any group of one that had maintained continuous coverage (defined as having had coverage within the last 60 days) from any source would be rated in the first year (and thereafter as long as the business continued) with all small-groups; that is, they would not be medically underwritten. Further, groups of one that provide proof of continuous coverage when first applying for group coverage would not be required to wait for an open enrollment period to be eligible for group coverage and would not be required to show proof of income from self-employment.

In sum, our analysis leads us to conclude that Maryland's small-group market is operating quite well. The problems that are evident—rapidly rising premiums and a decline in the number of carriers—are being experienced by states across the country and do not seem to be significantly related to small-group market reforms. The changes we recommend are fine tuning in a system that does not need a major overhaul.

Assessment of the Performance of Small-Group Health Insurance Market Reforms in Maryland

In the 2001 legislative session, the Maryland legislature passed House Bill 695/Senate Bill 457 "Health Insurance Study of Maryland's Small Group Market," which required that an independent consultant be commissioned to conduct a study comparing the performance of Maryland's small-group health-insurance market reform law to that of other states. The legislature also required the consultant to provide periodic updates to an impendent advisory committee made up of insurers, agents and brokers, and small employers. This report is the result of that study.

THE CONTEXT—THE PURPOSE THE STUDY SERVES

Presumably, the motivation that lies behind the legislature's decision to commission this study is a concern that the residents of the state, specifically those who work for small employers, have access to affordable, adequate health insurance. Small employers face particular disadvantages in getting affordable health coverage. They do not have the time, expertise, or research capabilities that large employers can bring to bear to find the most suitable and affordable health plan for their workers. Each small employer represents only a small part of any insurer's business, so individual small employers have no bargaining power with health plans. Marketing, selling, and servicing small employers is more expensive for insurers because of the diseconomies associated with their small size, so small employers pay more for administrative costs. These costs account for about 20 percent to 25 percent of total premiums for small employers, compared to about 10 percent for large employers.[2] Finally, the

[2]U.S. General Accounting Office, *Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage,* GAO-02-8, October 2001, p. 14. According to Maryland law, minimum loss ratios (the proportion of premium payments allocated to pay medical claims) cannot be lower than 75 percent. In effect, this means that the state would reject proposed rates with administrative costs plus profits exceeding 25 percent.

per-employee cost of providing medical treatment for small-firm workers and their families is likely to vary widely from group to group and from year to year, much more than for large employers. This difference is due to the "law of large numbers": employers with many employees are likely to have a few who become very sick and require expensive medical care, but the average cost remains predictable and relatively stable because the high costs associated with these few people are spread over the whole employee population. But if a small employer has one or two people who require expensive care, the average cost per employee can be very high. Insurers take account of this inability to spread the risk over a large employee population, and, in the absence of legal prohibitions, base each small employer's premium on the risk associated with the group's workers and dependents.[3] Before the days of small-group reform, the result could be prohibitively high premiums, or even denial of coverage, for small employers whose employees included a few people deemed to be high risk.

Not surprisingly, small employers are much less likely to offer health coverage than large companies. For example, in 1999 in the U.S. as a whole, only 39 percent of firms with fewer than 10 employees offered coverage, whereas 95 percent of those with 100 to 999 employees did so. Maryland firms at every size, especially the smallest firms, were more likely to offer coverage than in the U.S. as a whole—for example, more than half of even the smallest firms (those with fewer than 10 workers) offered coverage. But the close relationship between firm size and likelihood that coverage is offered holds for Maryland as well, as shown in Table 1 below.

Table 1: Percent of firms that offer coverage, by firm size, U.S. and Maryland, 1999

Number of Employees	U.S.	Maryland
Fewer than 10	39%	51%
10 to 24	70%	72%
25 to 99	86%	89%
100 to 999	95%	100%

Source: Medical Expenditure Panel Survey, Health Insurance Component Analytical Tool (MEPSnet/IC). January 2001. Agency for Healthcare Research and Quality, Rockville, MD.
http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.asp

In 1993 the Maryland legislature passed comprehensive reforms of the small-group insurance laws to make health care coverage more affordable and accessible to small employers. Implementation of these reforms in 1994 was followed by a period when more small employers

[3] By pooling all small groups together, an insurer would be able to apply the law of large numbers and charge all small employers the same "community" rate. But no single (non dominant) insurer could profitably do this unless others all agreed to do so. Without such agreement, some insurer could always profit by not community rating but instead rating on the basis of risk, offering lower rates to healthy, low-risk firms, and thereby siphoning off the low-risk business. This would leave the insurers who continued to community rate with predominantly higher-risk, high-cost business, forcing the community rate upwards and encouraging more low-risk groups to switch to other insurers. The process of risk segmentation would continue until all insurers were forced to abandon community rating and switch to risk rating. Community rating or modified versions of it are sustainable only if the law requires all insurers to follow the same rating rules or if, as in a few states, one insurer dominates the small-group market.

were buying coverage and premium increases were more modest than those experienced previously. For example, between 1995 and 1999, the number of employers offering coverage increased by 34.2 percent (from 43,595 to 58,495), and the number of people with coverage increased by 18.4 percent (from 402,411 to 476,622).[4] (It would be inappropriate, however, to conclude, without careful research, that these positive outcomes were caused by the reforms. Similar results were occurring in many states, including those with weaker reforms).

But health insurance premiums are rising rapidly again, which creates financial hardships for many employers and employees and deters some small employers from offering coverage. Since these large premium increases are coming at a time when the economy has slowed, the problems are exacerbated, and there is reason to be concerned that the ranks of the uninsured could increase. This seems like an especially appropriate time to reassess aspects of Maryland's small-group insurance reform laws to make certain that they are still serving their intended functions and not creating unintended problems.

Maryland, like every state, has significant numbers of small employers who do not offer health insurance. The most recently available data from the Health Care Commission indicates that more than 55 percent of Maryland small employers (defined as those with 50 or fewer employees) offer coverage. Of course, some proportion of the people who are employed by the 45 percent or so of small employers who do not offer coverage have health insurance from other sources. They are covered by a spouse's or a parent's health plan, they have purchased individual coverage, or their children (and in some cases, the parents) are covered by public programs like Medicaid or the State Children's Health Insurance Program (S-CHIP). A recent study estimates that for the nation as a whole, 59 percent of workers in firms with fewer than 50 workers have alternative sources of health coverage available to them.[5] The number in Maryland is likely to be at least that high, although the proportion, in Maryland and elsewhere, may be lower for workers in *uninsured* small firms.[6] Even though significant numbers of workers in uninsured small firms may have access to coverage from other sources, many others lack such access, and almost everyone agrees that, ideally, more small employers would offer health coverage.

As noted, since 1993 Maryland has had in place a set of small-group market reforms that were designed to make coverage more affordable and accessible. The fundamental question which this study is to address is this: *Are there elements of these reforms that might be altered in a way that would improve access to affordable coverage—that is, to cause more small employers to offer coverage and more employees to accept it—without creating other adverse consequences?*

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[4] Maryland Health Care Commission data.

[5] James D. Reschovsky and Jack Hadley, "Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly," Issue Brief: Findings from HSC, No. 46, Center for Studying Health Systems Change, December 2001.

[6] A disproportionate share of uninsured small firms are also low-wage firms. It is reasonable to assume that the spouses of low-wage workers are more likely than average to be employed, if at all, in low-wage firms that do not offer coverage.

To help answer that question, this study compares Maryland's small-group reforms with the relevant small-group reforms in six selected other states—New Jersey, Delaware, Virginia, North Carolina, Florida, and Colorado. The expectation is that the experience in these comparison states can provide insights about whether Maryland might make changes in its small-group laws, regulations, or policies to improve small access to health coverage by small employers and their workers.

Reform elements that are being reviewed

Two elements of the state's small-group reform laws are to be analyzed—the benefits required under the Comprehensive Standard Health Benefit Plan (hereafter referred to as the Standard Plan) and the premium rating limits.

At the time many states were legislating changes in their regulations governing the sale of health insurance to small employers, it was common to establish Standard (and in many states, Basic) Plans. These were plans that included a defined set of benefits that all small-group insurers were required to offer and sell under certain conditions. Typically, the Standard and Basic Plans were to be offered on a guaranteed-issue basis; that is, no applicant could be refused initial coverage or renewal of coverage, regardless of the health risk associated with the group. In addition, insurers were constrained from placing excessive exclusions of coverage for pre-existing medical conditions. Finally, restrictions were usually placed on the degree to which insurers could vary the premiums among small groups based on characteristics of the group, particularly the health risks of the people within the employee group.

In 1996, Congress passed legislation that superceded much of the state reform legislation.[7] The Health Insurance Portability and Accountability Act (HIPAA) required that *all* small-group policies—not just the Standard and Basic Plans—be offered on a guaranteed-issue and guaranteed-renewal basis and that pre-existing condition limits fall within specified ranges for all small-group plans. But Congress did not impose any requirements with respect to the benefits in Standard or Basic Plans or with regard to the extent to which insurers could vary premiums from employer to employer in the small-group market. These regulatory areas were left entirely to the states. Since states vary widely with regard to degree to which they constrain insurer practices in these two areas, it is these areas that are of special interest for this study.

[7] States were permitted to impose more restrictive standards; the federal standards are minimums.

The Standard Plan

Maryland's implementation of the Standard Plan concept is different from most states in several important respects. First, the Standard Plan is the *only* plan the insurers are permitted to offer in the small-group market. In virtually all other states—New Jersey is a notable exception—insurers are free to offer as many benefit options as they wish in addition to the Standard plan. The Maryland limitation is less restrictive than it at first appears, however, because insurers are allowed to add "riders" to enhance (but not diminish) the benefits, and, in fact, the vast majority of policies sold in the state include such riders.[8]

So the benefits in the Standard Plan, which are set by the Health Care Commission, represent a benefits floor, but insurers and employers have the flexibility to add any benefits they wish to make coverage more comprehensive. In setting the benefits floor, the Commission is constrained by a legislative requirement that the coverage be the actuarial equivalent of the benefits offered by a federally qualified HMO. Thus the Commission is limited in how far it can go in reducing benefits.

Another unusual aspect of the Maryland legislation is that, in effect, it also establishes a "ceiling" on the benefits of the Standard Plan. The average premium for the Standard Plan (without riders) must not cost more than 12 percent of the average annual wage. It is the responsibility of the Commission to make certain that this ceiling is not exceeded, and they can do so by varying the benefit package or the cost sharing provisions of the Standard Plan.

For purposes of this study, several questions about the Standard Plan need to be addressed with regard to the effects of its benefits structure on affordability:

1. Is the benefit floor appropriate—that is, do the benefits that are required in the Standard Plan cause the coverage to be too expensive and therefore out of reach for some small employers?
2. Would the state be better served by having a lower floor or by allowing more than one Standard Plan, some of which would have lower floors? That is, if coverage could be sold that was less comprehensive and thus less expensive, would more employers offer coverage?
3. Should the premium ceiling be altered in view of the fact that it is tied to the price of the Standard Plan without riders when, in fact, most employers buy policies with riders?
4. Does the Standard Plan still continue to serve a useful purpose?

These and related questions will be explored in the analysis below.

[8] One large small-group carrier reports that substantially less than 1 percent of its small-group policies are sold without riders.

Rating limits

Maryland, like most other states, has rules that limit the amount by which insurers can vary premium rates from group-to-group. The objective is to make coverage more affordable for higher-risk groups by spreading the risk more broadly. As noted earlier, prior to the introduction of rating limits, insurers based premiums on their assessment of the risk of each insured group. Groups with older, less healthy, higher-risk workers were charged much more than groups with younger, healthier, lower-risk workers. Without rating restrictions, the variation in premiums between the highest and lowest-risk group could vary by a ratio of 10:1 or even more.[9] Maryland's current law allows health plans to use only age and geographic location in determining premium differences and to vary rates by a total of no more than ±40 percent (other than for family size and plan benefit levels). This means that the highest-risk group cannot be charged a premium that is more than 2.3 times the rate charged to the lowest-risk group (±40 = range of 60 to 140; 140/60 = 2.3). The expected effect of such limits is, of course, to lower rates for higher-risk groups and increase them for lower-risk groups over what would be the case without such limits. As will be shown below, Maryland's rating rules permit less premium variation than those in most of the comparison states (though there are other states—New York and Vermont, for example—that permit less premium variation than allowed in Maryland).

The basic rating policy question to be addressed in the analysis is as follows:

> Are Maryland's rating limits too restrictive? That is, if insurers had greater latitude in setting rates, would more lower-risk small employers (often those with younger work forces) buy coverage? Would fewer currently insured employers drop coverage? Should other rating factors besides age and location be permitted?

THE METHODOLOGY

The methodology for this study was, in part, specified by the legislature. The legislature directed that the investigators compare Maryland's small-group market performance with that in other states. Our basic approach is to look at the experience of six other states, where the rules are different, to see if that experience can help us answer the questions outlined above. What is the experience in these six states with those different rules? Are a smaller or larger proportion of small firms offering coverage, and is adequate insurance less or more affordable? Are those differences attributable to differences in small-group insurance laws? Are there approaches to defining Standard Plans and establishing rating limits that work

[9] M. Susan Marquis and Stephen H. Long, "To Offer or Not to Offer: The Role of Price in Employers' Health Insurance Decisions," *HSR: Health Services Research,* Vol. 36, No. 5, October 2001, p. 946.

better to encourage broader coverage while still providing protections for higher-risk groups and providing adequate access to needed services?

Comparison states

After consultation with the Independent Advisory Committee to this project, we selected six states to compare with Maryland: New Jersey, Delaware, Virginia, North Carolina, Florida, and Colorado. We used various criteria in selecting the states. We wanted several states in close proximity to Maryland—Delaware and Virginia meet that criterion. We included some states with quite different regulatory approaches—Virginia and Delaware are the most notable examples. We tried to find states with somewhat similar regulatory approaches to those in Maryland—New Jersey and Colorado fit that description. In particular, in most states the Standard Plan accounts for only a tiny fraction of all small-group market sales, so that comparisons with the Standard Plan in those states are not particularly meaningful. New Jersey and Colorado are exceptions to that rule; in New Jersey only Standard Plans (five in total) are sold, and in Colorado the Standard Plan accounts for about 25 percent of the market. Florida and North Carolina were chosen because they fall somewhere in the middle with respect to regulatory approaches and because the researchers had done other related research in these states (and in Colorado), which gives us an in-depth understanding that we could not gain starting afresh in all states.

Data sources

Our data collection efforts had four primary components. We gathered data from the various state insurance departments and other state sources on the benefits in the Standard (and in some states) the Basic Plans. As noted, in all but Colorado and New Jersey, the Standard Plan accounts for a very small portion of small-group market sales. Because the bulk of the plans sold to small groups have different benefit structures from the Standard Plan, the experience with the Standard Plans is not representative of the market for most states. In such instances, we requested that insurers and/or agents send us the benefit structure of a plan that is representative of the typical plan sold in the state. We also requested this information from similar sources in Maryland because, as noted earlier, most Maryland small employers buy a benefit package that adds riders to the Standard Plan benefits. We think it is important to have some sense of the plans the small employers actually buy in Maryland as well as the other comparison states. This information will help us understand how closely the Standard Plan benefits match employers' own perceptions of their needs.

A second component of our research was interviews with state regulators, health plan representatives, and insurance agents and brokers. Our previous experience in doing research on the performance of small-group market reforms confirmed that the views and judgments of

these people can provide valuable insights about the performance—both successes and failures—of the small-group market. We interviewed a total of 36 people for this project, an average of 5 for every state. The interviews were done by telephone and typically lasted about one hour. In Maryland, the health plans representatives and agents we interviewed were members of the Independent Advisory Committee. Although it is important to be cautious about interpreting anecdotal information of this kind, our previous experience makes us confident that when there is general agreement among the interviewees, as there often was on this project, then the information gained through this process can usefully complement findings arrived at by other means.

A third major source of comparative data is the Medical Expenditure Panel Survey (MEPS), a national survey produced annually by the federal Agency for Healthcare Research and Quality. The survey data, which is widely used by health researchers, allows valid state-by-state comparisons about levels of insurance coverage and premiums by firm size. So the MEPS data is especially valuable for this study, particularly since the insurance departments in most of the study states did not have the detailed data we needed to make useful comparisons.

Because the MEPS data provides only limited ability to control for health coverage benefit differences from state to state, we turned to a fourth source of data for premium data using a uniform benefit package. We commissioned the National Association of Insurance Underwriters (NAHU) to get premium quotations from insurance agents in each of the study states to provide valid premium data for a common benefits package. With our assistance, they created a "fictitious" group of 10 employees with representative age and health-risk characteristics. They then asked insurance agents in all seven states to provide a premium quotation for this fictitious group, assuming a benefit structure that is similar to Maryland's Standard Plan benefits, with the exception that the sample plan included a lower deductible for prescription drugs to make comparisons with existing plans more feasible. The purpose of this study is to determine how small-group premiums in Maryland, assuming a group of representative risk, compare to those in other states. The results are one indication of the relative performance of the Maryland market.

Finally, we also reviewed our notes, reports, documents and analyses from our previous study of the small-group market in eight states. We also reviewed the findings of current research literature where that is appropriate to use in the analysis.

A cautionary note

We want to introduce an important note of caution in interpreting the findings from other states. *While the information from other states can be instructive, it will not provide an answer regarding the policies Maryland should adopt,* for several reasons.

First, as noted earlier, the Standard Plan provides a questionable basis of comparison among states. Except in Colorado and New Jersey (and, of course, Maryland), the Standard Plan accounts for few sales. And even in New Jersey and Maryland, many employers use riders to add to or (in New Jersey) subtract from the benefits of the Standard Plan.

Second, states may differ with respect to their underlying health care cost structures, the economic health of the state's employers, and the average risk profile of firms covered in the small-group market. These other variables can have important effects on the level and cost of coverage, apart from the effects of reform legislation. Lower or high costs in another state, for example, may have little or nothing to do with small-group reforms. The implication is that any apparent relationships between various aspects of performance and the nature of states' reform laws have to be interpreted with caution.

Third, and perhaps most important, even if the information from other states were entirely comparable, the experience in other states would not indicate what Maryland *should* do. Virtually all policy decisions regarding regulation of the small-group market involve difficult tradeoffs that require balancing conflicting objectives. Moving in one direction produces some desirable consequences while creating impediments to the achievement of other objectives. For example, allowing insurers greater latitude to base premiums on rating factors related to enrollees' health status would probably help to attract more low-risk individuals and groups. But at the same time, by making coverage more costly for high-risk individuals and groups, it may deter them from buying coverage. Deciding which tradeoffs to make is as much a matter of value judgments as it is objective analysis. States appropriately bring different values to these questions, and results which are seen as acceptable or even desirable in some states may not be viewed that way by people in Maryland. In deciding which tradeoffs to make, the people of Maryland may prefer a different balance than people in other states.

Independence of the study

Finally, we need to say a word about the independence and objectivity of this study. The legislature asked that the consultants be independent. We believe we have been true to the spirit of that requirement. We have consulted with the staff of the Health Care Commission to confirm that the direction and approach of our study was consistent with the objectives the legislature intended and that our work would be useful to the state. But the Commission staff have not influenced any of our findings or recommendations to any greater degree than others we have interviewed in Maryland. The views of the Commission staff and the Maryland Insurance Administration staff regarding Maryland's small-group market are given equal weight with those of the agents, brokers, and health plan representatives that we interviewed for the project.

The role of the Independent Advisory Committee to this study—composed of insurance carrier representatives, agents and brokers, and small employers—was to serve as a sounding board and to provide feedback as we defined the detailed approach to the study and after we had made the initial findings. The recommendations in this report are entirely those of the researchers. This assignment inherently requires that we analyze data that is less comprehensive than is ideal and sift through sometimes inconclusive evidence in generating debatable policy recommendations. We have been careful to make clear the source of the evidence we use and to indicate where the data leave room for conflicting interpretations. We have also taken pains to make explicit the tradeoffs that would be involved in accepting the recommendations that we make.

FINDINGS: THE STUDY EVIDENCE

The first task is to determine how Maryland's small-group market is performing. In assessing how that market operates, we examine performance in four areas that might be influenced by the state's rating laws or the benefits mandated in the Standard Plan: coverage rates, premium levels and affordability, premium trends, and degree of market competition.

Coverage rates for small-group insurance: what proportion of small employers offer coverage?

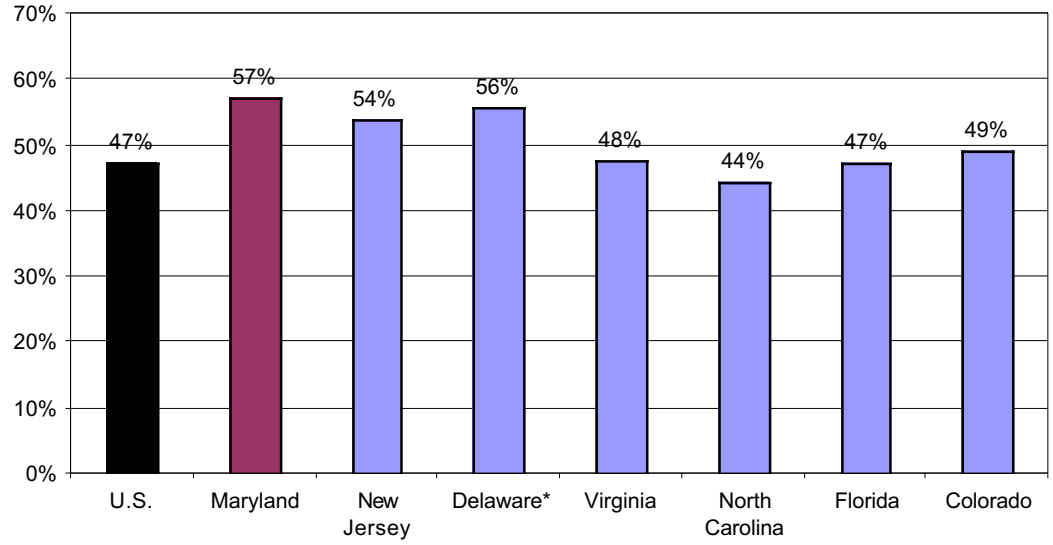
Ideally, all employers would offer group coverage for their workers. Most Americans who have private health insurance are covered through employer-sponsored plans. Since individually purchased coverage is substantially more expensive than employer-sponsored coverage, workers who do not have the option of being covered through their place of work are at a financial disadvantage, and many will simply forego coverage because of the expense and hassles of buying individual insurance.

This study focuses specifically on the firms covered by the small-group reform laws, that is, those with 50 or fewer employees. Good state-by-state data is available for this group of employers from the previously discussed MEPS.[10] This survey uses a common methodology for all states and is subject to statistical tests to ensure validity and reliability and is thus more accurate for making comparisons among states than the data we collected (where possible) from departments of insurance in the various study states. (Only Maryland among the study states, for example, collects data on the proportion of small employers that offer coverage.) The disadvantage of using this data source is that the latest year for which data is available is 1999. Unless otherwise indicated, all state comparisons in this report rely on the MEPS data.

[10] MEPs uses a size breakdown of *fewer than 50* employees, whereas Maryland defines small employers as those with *50 or fewer* employees. This difference is inconsequential for our data analysis.

As shown in Figure 1 below, Maryland small establishments more often offer coverage than establishments in any of the study states or in the U.S. as a whole. About 57 percent of Maryland employers with fewer than 50 employees offered coverage in 1999,[11] whereas the U.S. average was 47 percent, and in four of the study states fewer than half of the small employers offered coverage. So by this test, Maryland appears to perform well: compared to other states, coverage is more commonly available to employees of small firms.

Figure 1: Percent of private-sector establishments that offer health insurance, firm size fewer than 50 employees, 1999



*Only 1998 data is available for Delaware. The number shown here for 1999 assumes the same rate of increase for Delaware between 1998 and 1999 as the average for New Jersey, Maryland, and Virginia. (12%).

Source: Medical Expenditure Panel Survey, Health Insurance Component Analytical Tool (MEPSnet/IC). January 2001. Agency for Healthcare Research and Quality, Rockville, MD.
http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.asp

It is important to recognize that for most states other than Maryland (New Jersey is an exception), the data cannot be used to make judgments about the *adequacy* of coverage. Only Maryland and New Jersey require that small employers offer coverage specified in a Standard Plan (five Standard Plans in New Jersey). Although all the study states have Standard Plans, there is no requirement that the plans actually sold be as comprehensive as the Standard Plan benefits. So coverage for some employers in other states may be considerably less comprehensive than the coverage that Maryland small employers offer.

[11] Here and elsewhere in this report, the data we rely on from MEPS sometimes differs from the data available from the Health Care Commission. Some discrepancies are virtually always present when several data sources are used. The Commission's data is normally based on actual reports from insurers for an entire population. The MEPS data is based on samples, not actual counts, and some of the differences are probably due to sampling problems in the MEPS data, since even large samples are not perfect reflections of actual populations. With respect to the particular statistic in this chart, the Commission data indicates that 55 percent of small employers offer coverage.

Premium levels and affordability

Affordability depends on the relationship between premium prices and income, as well as on the amount that employers contribute to coverage for their workers. The hope would be that premiums in Maryland are not far out of line with premiums in other states. Since Maryland requires that all small-group plans sold in the state include the Standard Plan benefits, if those benefits are overly comprehensive, they could cause premiums in the state to be higher than for the plans employers choose in other states, where they have the option of choosing less comprehensive coverage.

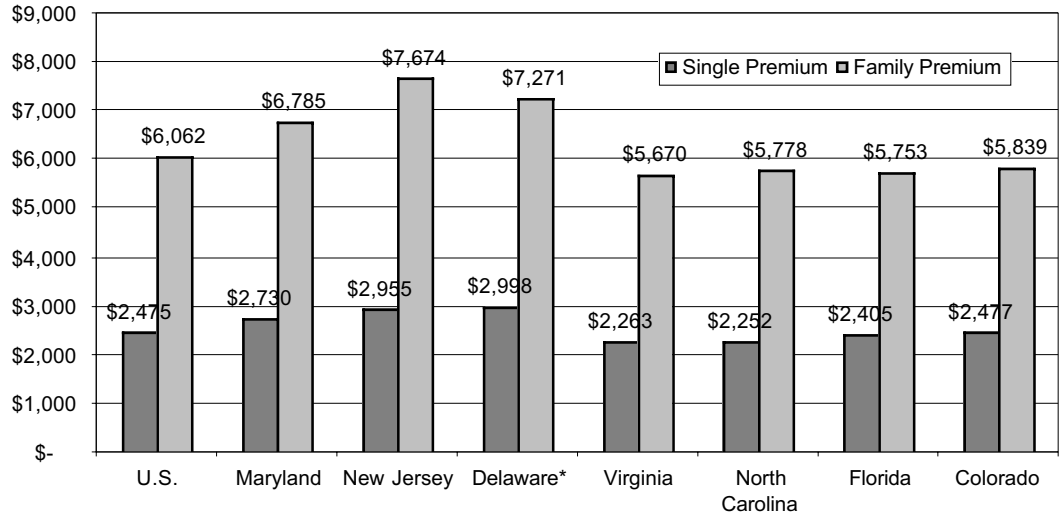
Cost comparisons based on average premiums

Although this study focuses especially on the affordability of the Standard Plan in Maryland compared to the study states, it is still important to know how much small employers spend on average for the coverage they actually purchase, which, as noted earlier, almost always includes riders that make it more comprehensive than the Standard Plan benefits. Maryland's laws regarding rating and Standard Plan benefits may or may not have an important influence on premium levels and affordability. But if there are effects, they are important in terms of the way they influence price and affordability of the coverage that employers *actually buy.* That would be reflected in the data below. Figure 2 shows the average 1999 premium for family coverage and single (employee-only) coverage for establishments with fewer than 50 employees in Maryland, the U.S., and the study states.

In interpreting the data in Figure 2, it is important to know that the numbers depict average premiums without controlling for benefit differences, employer-employee premiums shares, regional medical cost differences, average wages, or any other factors which can have important effects on costs and affordability. The data simply show what small employers pay for coverage on average. In 1999, average premiums in Maryland for family coverage ($6,785) and single coverage ($2,735)[12] were 11.9 percent and 10.3 percent higher than the U.S. average ($6,062 and $2,475 respectively), higher than in Virginia, North Carolina, Florida, and Colorado, but lower than in New Jersey and Delaware.

[12] According to Commission data, the average individual premium was $2,049 in 1999, and the average family premium was $5,776.

Figure 2: Average total premium per enrolled employee for single and family coverage at private-sector establishments that offer health insurance, firm size fewer than 50 employees, 1999



*Only 1998 data is available for Delaware. The number shown here for 1999 assumes the same rate of increase for Delaware between 1998 and 1999 as the average for New Jersey, Maryland, and Virginia.

Source: Medical Expenditure Panel Survey, Health Insurance Component Analytical Tool (MEPSnet/IC). January 2001. Agency for Healthcare Research and Quality, Rockville, MD.
http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.asp

Based on this limited MEPS data for these states only, there does not seem to be any obvious relationship between premiums and the degree to which insurers are constrained from varying rates. Maryland and New Jersey have tight rating constraints and higher premiums, but Florida[13] and Colorado are like Maryland in prohibiting rating on the basis of health status, yet they have lower premiums. And Delaware, which has very lenient laws, has premiums above those in Maryland, while Virginia, also with very lenient laws, has rates well below Maryland. Although there does not seem to be any detectable relationship between rating laws and premium levels in these states, such a relationship could be hidden by other factors that are not controlled for. (In fact, we later cite a study based on all 50 states that does find somewhat higher rates in states with restrictive rating laws).

Cost comparisons based on common benefits

The previous comparisons were for the average coverage costs in each state, and thus they were not controlled for differences in benefits. To get a more valid comparison of relative costs, it is desirable to know how much coverage would cost in each state *for approximately the same benefit package.* To get such data, we commissioned the National Association of

[13] At the time this data was collected, Florida did not permit rate variation based on health status. Beginning July 2000, the rating rules were modified to permit rate variation of ± 15 percent for health status.

Health Underwriters to solicit premium quotations from agents and brokers in Maryland and the other study states for coverage comparable to the Maryland Standard Plan with the addition of lower cost sharing for prescription drugs coverage. (This change for drugs was necessary to get comparable benefit packages in other states.) We used the following approach. We developed a fictional small business composed of 10 employees of varying age and health conditions so that the group represented a group of average risk—neither low-risk nor high-risk. Imposing this condition was important. Since Maryland allows less latitude to insurers to vary premiums according to risk, if we had asked for premium quotations for a group with no adverse health conditions and below-average age, Maryland's rates would have been "artificially" higher than those in states that allow rating based on age or health risk. Similarly, if we had asked for quotations for a group of above-average risk, Maryland's rate would have been artificially lower than those in states with liberal rating rules. (See Appendix I for the age and health characteristics of the fictional group.) In selecting agents to provide quotations, NAHU selected representative cities from each state. We asked them, where possible, to select a PPO plan with benefits as close as possible to the benefits in Maryland's Standard Plan and to select an insurer that was representative of their business.[14] The results from the study are summarized in Table 2 below.[15]

The survey results indicate that the cost of coverage in Maryland for a group of average risk is somewhat lower than in most of the study states. The quotation for the fictional group was $3,247.09. Only North Carolina had lower-priced coverage ($3,016.17). The average for the five study states was $3,556.43, so Maryland's rate was 91 percent of the average for the other states. It is important to note that the coverage in most states was similar to but not identical to the Maryland Standard Plan and that the premiums are not controlled for differences in regional medical costs.

[14] In Colorado, a PPO plan was not available, so the quotation is for HMO coverage. The benefits vary somewhat from state to state because exactly comparable coverage was not available.

[15] We were unable to obtain information for Delaware. All carriers offering small-group coverage in the state currently require each group member to go through complete medical underwriting before a quotation can be issued. In addition, these carriers require proof of last year's rates before providing a quotation. Obviously, we were unable to provide such information for our fictional group.

Table 2: Premium quotations for coverage comparable to Maryland's Standard Plan with the addition of lower cost sharing for prescription drugs, December 2001.

Location	*Monthly Premium*	*Premium Details*	*Plan Description*	*Low-Risk Group Discount*
Baltimore, Maryland	$3247.09	2@$636.67/Family 1@$488.21/Spouse 7@$212.22/Single	Maryland Comprehensive Standard Health Benefits Plan	None
Denver, Colorado	$3446.96	1 Female 25@$173.14 1 Male 27@$184.68 1 Male 30 @$184.68 1 Female 34+Spouse @$438.62 1 Male 37+Family @$703.12 1 Male 37@$230.85 1 Female 39 @$230.85 1 Male 41+Family @$703.12 1 Female 45@$244.70 1 Male 55 @$353.20	HMO plan with a $20 office visit copay. $2000/$4500 out-of-pocket limit. $100 emergency copay (waived if admitted). $10/$20 RX coverage for 30-day retail supply.	None
Orlando, Florida	$3592.57	2 Males <29@$121.66 1 Female <29@$293.08 1 Male 35-39@ $153.26 1 Female 35-39@$266.28 1 Female 40-44 @$295.82 1 Male 50-54 @$360.62 1 Couple 30-34@$439.56 1 Family 35-39 @$740.75 1 Family 40-44 @$778.86	POS Plan with a $500/$1000 nonreferred deductible. 80% coninsurance rate. Primary office visit copay is $10. Specialty care copay is $25. Emergency room visit copay is $100 (waived if admitted). RX coverage is $10/$15/$30 for 30-day pharmacy and $20/$30/$60 for 90-day mail-order.	None
Trenton, New Jersey	$4448.28 *	2@$904.04/Family 1@$618.39/Spouse 7@$288.83/Single	POS plan with a $1000 deductible. 80% coinsurance rate and $2000 stop-loss limit. Office visit copay is $20 and RX coverage is $7/$15/$35 for a 30-day supply.	None
Raleigh, North Carolina	$3016.17	1 Female 25@$237.49 1 Male 27@$80.66 1 Male 30 @$118.75 1 Female 34+Spouse @$360.72 1 Male 37+Family @$552.73 1 Male 37@$129.95 1 Female 39 @$230.77 1 Male 41+Family @$590.37 1 Female 45@$277.83 1 Male 55@$436.90	PPO plan with a $1000/$2000 deductible. 90%/70% coinsurance rate. Primary care office visit is $20 and specialty care copay is $30. $100 emergency room copay is $100 (waived if admitted. RX coverage is $10/$20/$30 for a 30-day supply.	20%
Richmond, Virginia	$3278.16	1 Female 25@$176.32 1 Male 27@$167.32 1 Male 30 @$167.32 1 Female 34+Spouse @$450.43 1 Male 37+Family @$645.01 1 Male 37@$192.31 1 Female 39 @$192.31 1 Male 41+Family @$708.80 1 Female 45@$231.42 1 Male 55@$355.92	This is a PPO plan with a $500/$1000 out-of-network deductible and a $3000/$6000 stop-loss limit. Plan includes a $20 office visit copay. 80% coinsurance rate for out-of-network coverage. RX Coverage is a $10/20/$35 copay rate for a 30-day retail supply and $20/$40/$70 for 90-day mail-order.	15%
Austin, Texas**	$2544.06	2@$515.90/Family 1@$328.21/Spouse 7@$169.15/Single	This is a PPO plan with a $1000/$2000 in-network/out-of-network deductible. The plan has a $7500/$15000 stop-loss limit. RX Coverage is a $10/20/40/25% copay rate for a 30-day retail supply.	None

*The high premium rate for New Jersey needs to be interpreted with caution. One reason that the average premium is higher than premiums for PPO plans elsewhere is that the quotation for New Jersey is for a POS plan, and the co-pays and deductibles in POS plans in New Jersey apply only to the out-of-network portion of benefits. The in-network portion is structured like an HMO with no deductibles (except for hospital stays) and only co-pays, not co-insurance.

**Because data for Delaware was not available, data for Austin, Texas, is included, since this location was also used for a study cited by the General Accounting Office that is cited later.

Table 3: Family and single premiums for all health plan types for firms with fewer than 50 workers as percent of average annual pay, by state, 1999.

	1999 Pay**	Family Coverage		Single Coverage	
		Premium	Premium as % of Pay	Premium	Premium as % of Pay
U.S.	$ 33,340	$ 6,062	18.2%	$ 2,475	7.4%
Maryland	*$ 34,489*	*$ 6,785*	*19.7%*	*$ 2,730*	*7.9%*
New Jersey	$ 41,038	$ 7,674	18.7%	$ 2,955	7.2%
Delaware*	$ 35,157	$ 7,271	20.7%	$ 2,998	8.5%
Virginia	$ 33,025	$ 5,670	17.2%	$ 2,263	6.9%
North Carolina	$ 29,462	$ 5,778	19.6%	$ 2,252	7.6%
Florida	$ 28,935	$ 5,753	19.9%	$ 2,405	8.3%
Colorado	$ 34,191	$ 5,839	17.1%	$ 2,477	7.2%

*Only 1998 data is available for Delaware. The number shown here for 1999 assumes the same rate of increase for Delaware between 1998 and 1999 as the average for New Jersey, Maryland, and Virginia.

**Source: BLS, http://stats.bls.gov/news.release/annpay.t01.htm; and Medical Expenditure Panel Survey, Health Insurance Component Analytical Tool (MEPSnet/IC). January 2001. Agency for Healthcare Research and Quality, Rockville, MD. http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.asp

Affordability

Although the previous analyses compare premiums in Maryland with other states, they do not address affordability. Affordability can be measured in a variety of ways, but one reasonable way is to compare average premiums for all small employers in each state with the average pay of workers in the state. That comparison appears in Table 3 above. There are not major differences among the states by this measure of affordability. The range in the study states is from a low of 17.1 percent of pay for family coverage (Colorado) to a high of 20.7 percent (Delaware), with Maryland in the middle with 19.7 percent.[16] The rankings for single coverage are similar. Single coverage represents 7.9 percent of pay in Maryland.[17] In sum, by this measure of affordability, Maryland's experience seems much like that of the other study states and the U.S. as a whole.

Affordability could be considered to be affected by the way small employers and their employees share in the payment of the premium[18] (see Figure 3). In Maryland, small employers pay about 79 percent of the premium for both single and family coverage, so employees pay

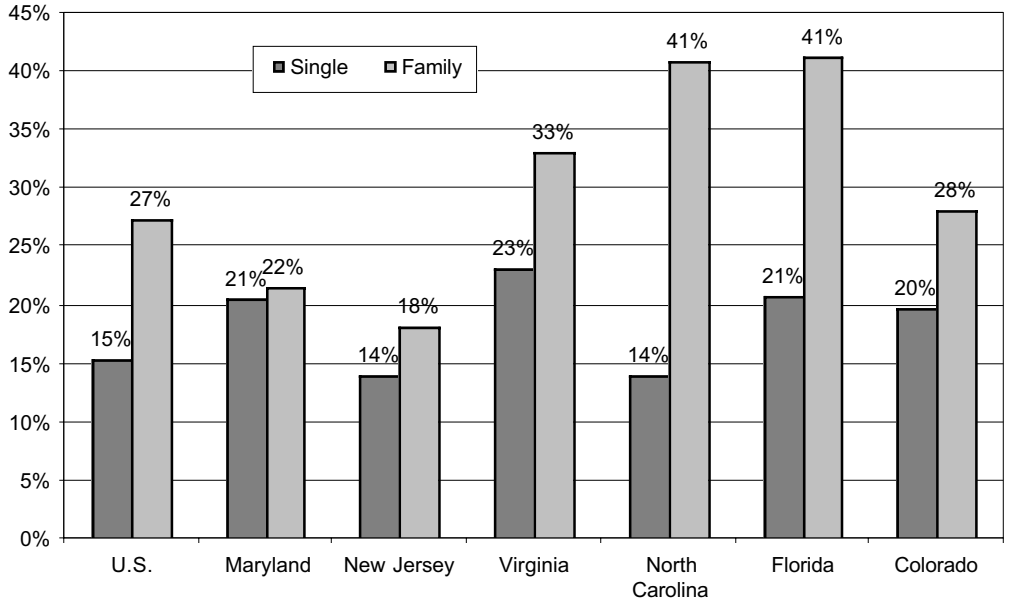
[16] If we use the premium data from the Health Care Commission, the family coverage as a percentage of pay would be 16.7 percent.

[17] If we use the premium data from the Health Care Commission, single coverage as a percentage of pay would be 5.9 percent.

[18] The prevailing view among economists is that employees, in effect, ultimately bear the cost of the full premium regardless of the nominal division between employer and employee. They argue that when the employer pays a larger amount for the health coverage premium, there is an offsetting reduction in money wages, so that total employee compensation remains the same regardless of who appears to pay the premium. If this view is correct, the better measure of affordability is the ratio of total premiums to average pay discussed in the previous paragraph.

about 21 percent. The employer share for single coverage is lower than for the U.S. as a whole (85 percent) and lower than about half of the study states (data for Delaware is not available for 1999); so Maryland employees pay a somewhat larger share for single coverage than is the case in a number of other states. On the other hand, employers contribute more toward family coverage in Maryland (89 percent) than in the U.S. (73 percent) and all of the study states except New Jersey. So while the total premium (employer and employee share) in Maryland is about the same percentage of pay as in other states, Maryland employers contribute less toward single coverage and somewhat more to the premium for family coverage than is typical for the U.S. and most of the study states. This makes single coverage somewhat less affordable for employees and family coverage somewhat more affordable in Maryland than elsewhere, other things being equal.

Figure 3: Percent of total premiums contributed by employees enrolled in establishments that offer health insurance, firm size fewer than 50 employees, 1999



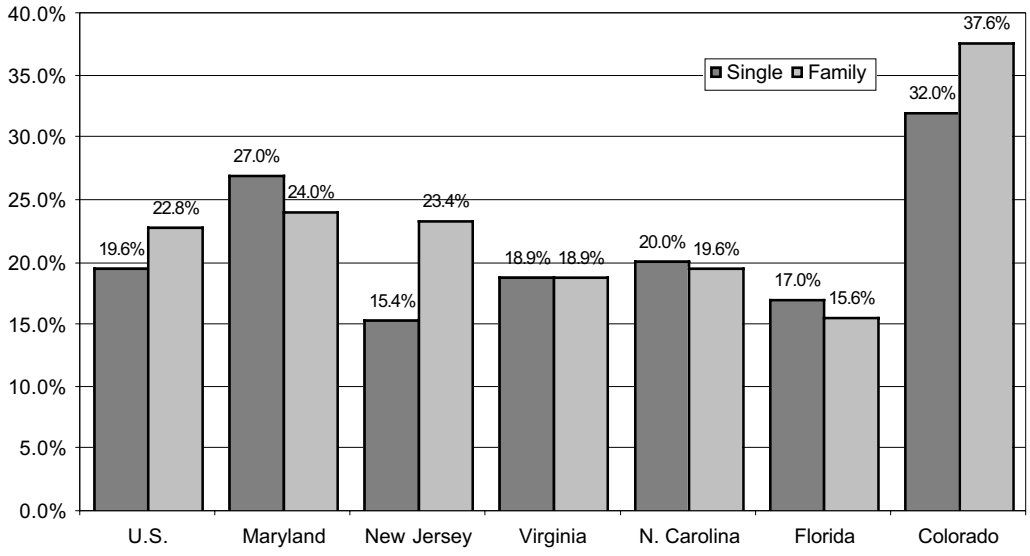
Source: Medical Expenditure Panel Survey, Health Insurance Component Analytical Tool (MEPSnet/IC). January 2001. Agency for Healthcare Research and Quality, Rockville, MD.
http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.asp

Premium trends

Another relevant measure of small-group market performance is the rate of increase of insurance premiums. The available data is limited to the period 1996 to 1999. During that period, premiums for both single and family coverage increased more rapidly in Maryland

(27.0 percent and 24.0 percent respectively[19]) than in the U.S. as a whole (19.6 percent and 22.8 percent) or than in the other study states except Colorado (see Figure 4, 5, and 6).[20] The reasons for this difference are not clear. Maryland and Colorado are both states with more restrictive rating reforms and relatively comprehensive Standard Plans that are a significant portion of total sales, but so is New Jersey, and its rate of increase was more modest (15.4 percent and 23.4 percent).

Figure 4: Percent change single and family premiums, establishment size equal fewer than 50 employees, 1996-1999.



Source: Medical Expenditure Panel Survey, Health Insurance Component Analytical Tool (MEPSnet/IC). January 2001. Agency for Healthcare Research and Quality, Rockville, MD.
http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.asp

[19] According to Health Care Commission data, the premium increase for single coverage between 1996 and 1999 was 27 percent, the same as the statistic based on MEPS data. For family coverage, the increases was 8.5 percent. It seems likely that there is some problem with the Commission data for family coverage, since this figure is so far out of line with the Commission's data for single coverage and from the MEPS data. If there is a problem, it is likely related to errors in reporting from insurance carriers.

[20] Delaware was excluded from this analysis because data is available only for 1998.

Figure 5: Average total single premium per enrolled employee at private-sector establishments that offer health insurance, firm size fewer than 50 employees, 1996-1999

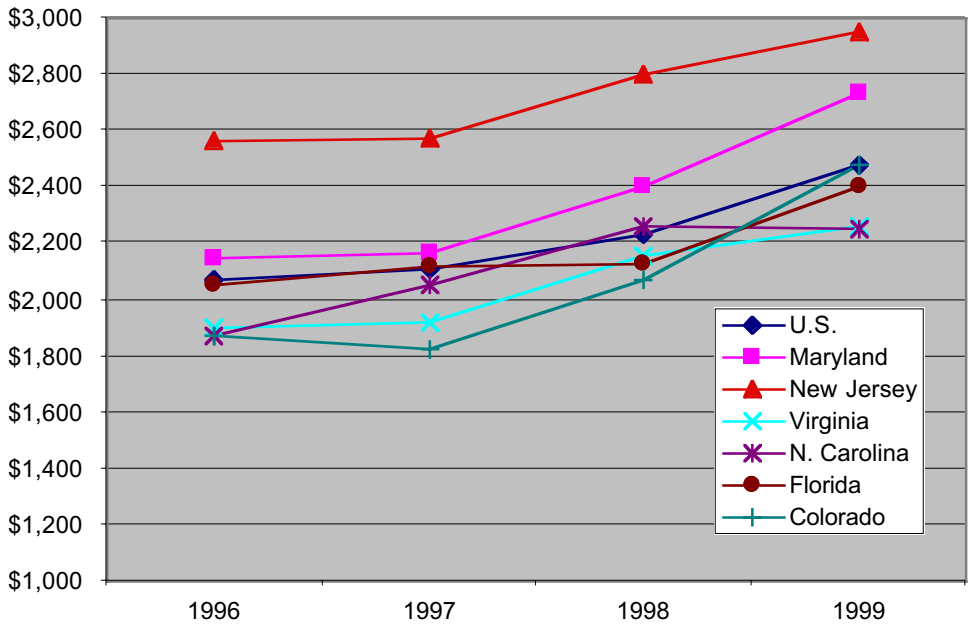
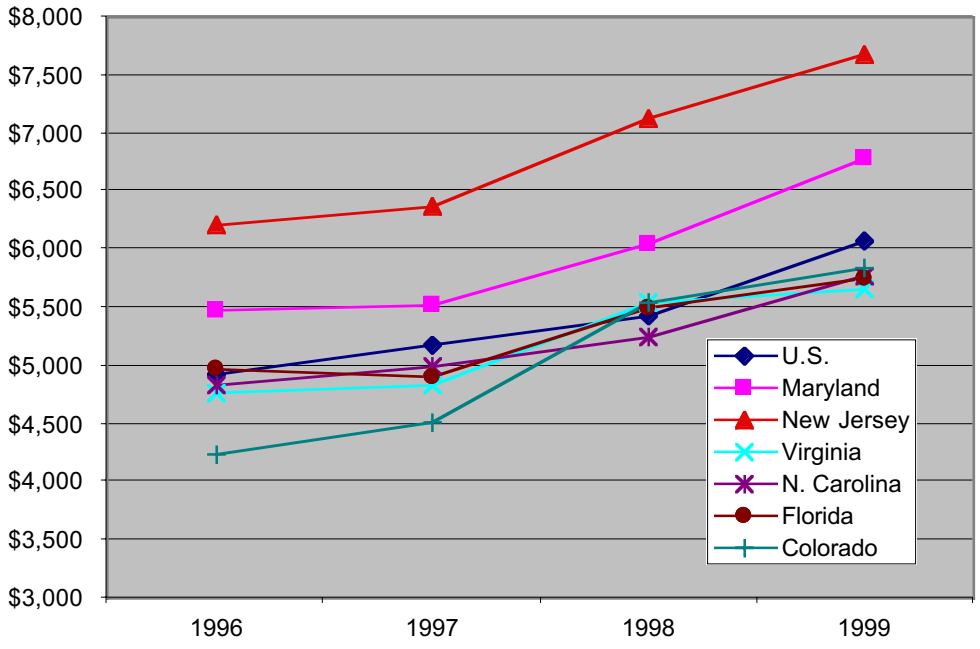


Figure 6: Average total family premium per enrolled employee at private-sector establishments that offer health insurance, firm size fewer than 50 employees, 1996-1999



Source: Medical Expenditure Panel Survey, Health Insurance Component Analytical Tool (MEPSnet/IC). January 2001. Agency for Healthcare Research and Quality, Rockville, MD.
http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.asp

Degree of competition—changes in numbers of health plans offering coverage

Economists agree that vigorous competition among competing firms in an industry is necessary to ensure efficiency, low prices, and good service. There is less agreement about how many firms must be in competition to produce these good results, but if the number becomes too small, performance is likely to be less than optimal. The number of competing health insurers and health plans has been decreasing rapidly across the country in the last decade or so, as major competitors merge and some companies disappear entirely. The movement toward managed care and away from indemnity coverage has been a major cause of this consolidation, as insurers concluded that only large firms, with major resources, could effectively develop, market, and maintain viable managed care systems. In addition, the intense competition of recent years has prompted many insurers to consolidate their activities to concentrate on markets where they deemed they could be most profitable. The consequence has been that virtually all states have experienced a reduction in the number of carriers, especially carriers operating in the small-group market. This reduction has probably been hastened by small-group market reforms. The insurers that succeeded by being especially skillful in identifying and selling coverage primarily to lower-risk groups lose their competitive advantage when states restrict all insurers' ability to risk-select.

Maryland has experienced a reduction in the number of health plans operating in the small-group market. Between 1995 and 1999, the number declined from 37 to 23. But in terms of the effect on competition, this statistic can be misleading. As is true in many states, a few carriers tend to dominate the market, and many of the carriers that leave never accounted for a significant market share. So their demise may not have much effect on competition. To illustrate, 12 carriers in Maryland that the Health Care Commission calls "prominent carriers"[21] accounted for about 80 percent of small-group business in 1995 and about 93 percent in 1999. So the real competition is between a few large health plans. Even so, if the market share controlled by a few competitors is used as a measure of competition, competition has declined. For example, between 1998 and 2000, the share of the two largest carriers jumped from 59 percent to 70 percent. Clearly, the number of health plans that can compete effectively across the state is not large, and the fact that just two firms control such a large market share diminishes competition.

Control of large market share by a few carriers is neither a new phenomenon nor unique to Maryland. In a great many states, the Blue Cross and Blue Shield plans (in either their original form or their reincarnations) historically have accounted for a large market share and continue to do so, reflecting the fact that originally they were essentially the only source of

[21] These are carriers that insured at least 5 percent of total lives or 10 percent of lives in any one particular delivery system in 1995; that is, the analysis is based on a consistent 12 carriers, defined historically, even though some carriers are no longer in the market.

health coverage in many states. And very commonly, just a few plans account for the bulk of the business. For example, in New Jersey, the four largest small-group carriers have a 68 percent market share.[22] In North Carolina, the top three carriers account for about 55 percent of the business.

Virtually all states are experiencing a decline in the number of carriers in the small-group market. Colorado reports that the number fell from around 80 in 1995 to fewer than 30 now,[23] with the very recent departure of Aetna causing significant problems for the state. In Delaware, the number of carriers declined from 39 to 17 between 1993 and 2001, and again, the recent departure of Aetna is cause for concern. In Florida, the number of active carriers declined from about 100 in 1998 to about 35 now, though none of those leaving had a large market share. In almost all the study states, the state regulators we spoke to expressed concern about the loss of carriers. The concern was especially acute when a carrier that accounted for a significant share of the small-group business had left the state. This concern did not vary based on the extent to which the state regulated the small-group market, reinforcing the conclusion that larger economic forces are primarily responsible for consolidation among insurers serving this market.

In sum, Maryland is like most states in having fewer competitors in the small-group market than in the past. But the degree of concentration seems to be even higher in Maryland than in a number of other states. When only two carriers account for 70 percent of the small-group sales, it is clear that their actions can have a large effect on the market as a whole, which gives them market power. In contrast, in a truly competitive market, no single firm's actions can have a significant effect on the market. The important question is whether the degree of competition in the small-group market is adequate. Our informants had somewhat mixed views on that issue. Several of the major health plans said that competition was intense—and played out on a "level playing field" because of market reforms, according to one insurance informant. The insurers indicated that they were always anxious about the prospect of losing market share to competitors. On the other hand, several observers expressed the view that conditions allowed carriers to avoid intense competition in some circumstances, particularly with respect to the price of "riders" to the Standard Plan.

In any case, it seems unlikely that anything that the State of Maryland could do would reverse the decline in the number of carriers competing in the state, since the trend is national. And it is equally unlikely that the state could do anything that would cause market share to be more evenly distributed among carriers operating in the state. On the other hand, some carriers that are not in Maryland are in Virginia, and it is likely that the difference in the regulatory environment has an influence on the carriers' decisions to locate in one state and

[22] State of New Jersey, Small Employer Health Benefits Program, Enrollment Report for the second quarter of 2001, revised 10/31/2001.
[23] Interview with Susan Gambrill, special assistant to the insurance commissioner, November 2001.

not another. Maryland's tight rating requirements (in contrast to those in Virginia) are probably one factor that deters some carriers from operating in the state, but several informants indicated that there are others factors. The state has a general reputation for being more "active" than some other states in dealings with insurers, and, according to one informant, it is harder to get quick responses from the Insurance Administration in Maryland than in some other states, which discourages some insurers from operating in the state.

Assessments of performance by key informants

As noted, our data-gathering process included a series of interviews with key informants in each state, usually including state regulators, insurance agents and brokers, and health plan executives. In Maryland, we had formal interviews with two insurance agents and brokers, six state regulators, and three insurance company representatives. Because there was substantial consensus on most issues, we think it is appropriate to report their views of the performance of Maryland small-group market, and where appropriate to compare those views with those of key informants in other states.

The informants in Maryland and elsewhere were unanimous in identifying rapid premium increases and the high cost of coverage as being an important problem that has re-emerged with a vengeance in the last year or so. Insurers and agents in Maryland report that average increases are in the 20 percent range or even higher and that individual groups can get increases twice that large or more. (The reports in all the other study states were similar.) Everyone agreed that small employers were upset about this cost escalation and were trying to find ways to bring their costs into line with their ability to pay, although the accounts of employers actually dropping coverage were few. Instead, they were considering adjusting benefits by increasing cost-sharing of various kinds, paying a smaller portion of the premium, or contributing less to dependent coverage. No one in Maryland or elsewhere pointed to market reforms as a significant cause of this cost escalation. The consensus was that the cost increases were attributable to underlying increases in the cost of medical treatment and the insurers' need to recover from past losses, often brought on by their efforts in the 1990s to keep premiums low to avoid losing market share in a period of intense competition for customers during the shift from indemnity coverage to managed care. This cycle of relatively low prices for a time followed by a period of rapid price increases is an old phenomenon in the insurance industry, often referred to as the "underwriting cycle."

Among those we interviewed in Maryland, there was virtually unanimous agreement that the market reforms have had beneficial effects for small employers, making coverage more readily available and affordable for higher-risk groups and improving the basis on which competition takes place (that is, not competition to avoid high-risk groups). One insurer representative pointed to the limits on medical underwriting as a "huge benefit" of small-group reform,

and also said that the Standard Plan had greatly simplified the market, making it much easier for employers to make choices. Nevertheless, several respondents expressed mild support for relaxing the rating rules to permit somewhat more variation for age or to allow more rating factors to be used (such as allowing rating for group size or permitting discounts for not smoking). Even so, few who took this view thought the result would be a large increase in the number of small employers that offer coverage, and others acknowledged that the trade-off for bringing in more lower-risk groups would likely be to make coverage less affordable for higher-risk groups.

Views about the Standard Plan were more varied. One person thought the Standard Plan had helped to put competition on the right basis, by forcing PPOs to offer coverage equivalent to that offered by HMOs and thus not allowing them to compete for lower-risk groups by scaling back coverage to a level that would appeal primarily to healthy groups. Several suggested that the benefits were too comprehensive, not giving employees the option to choose to exclude drug coverage, for example. On the other hand, even these people acknowledged that virtually all groups add riders to reduce drug deductibles and other cost-sharing by patients, and several worried that having a less comprehensive package would encourage people to separate themselves according to risk, with the lower-risk groups buying less comprehensive coverage. One informant expressed the desire for even larger deductibles to permit employers to make high-deductible plans, including MSAs, available to their higher-income employees (who can afford the out-of-pocket costs).

Overall, apart from the concern about recent premium increases, there was no widespread dissatisfaction among those we interviewed in Maryland about the way the small-group market is performing. For the most part, people seemed to agree that the market reforms have worked well and that they have not created significant adverse consequences, although one or two people linked the decline in the number of small-group insurers to the market reforms. The reaction in other states was not markedly different.

RATING RESTRICTIONS

We turn now to an assessment of the way Maryland's small-group reforms compare to those in other states, beginning with an assessment of the rating restrictions.

In our interviews in the seven states, we asked whether there were problems with the existing rating limits and what changes would be desirable. These states reflect a broad range of rating approaches, as shown in Table 4. Maryland and New Jersey have similar and the most restrictive rating rules among the study states (but not in the nation as a whole).[24] At the

[24] Vermont and New York, for example, have pure community rating, which means they allow no variation for group characteristics.

other extreme, Virginia has no rating limits at all (except for the Standard and Essential Plans, which are inconsequential in terms of sales). In between are states that allow full rating for demographics (age, gender [where applicable], and geographic location) but no rate variation for individual health status (Colorado and, until recently, Florida), and other states that also allow differing, but limited, degrees of variation for individual health status or claims history (Delaware, North Carolina, and recently, Florida).

TABLE 4: COMPARISON OF RATING RULES IN MARYLAND AND STUDY STATES

State	*Rating for Demographics*	*Gender Rating Allowed*	*Rating for Health Status*
Maryland	2.3:1	No	None
New Jersey	2:1	Yes	None
Colorado	Full	No	None
Florida pre-2001	Full	Yes	None
Florida post 2000	Full	Yes	1.35:1
North Carolina	Full	Yes	1.5:1
Delaware	Full	Yes*	2.08:1*
Virginia	Full	Yes	Full

*In Delaware, rating for gender and location combined is limited to ± 10 percent.

Interview results

No clear patterns emerged from the experience in other states. For the most part, there was no widespread dissatisfaction with the rating laws regardless of the restrictiveness of those laws. In states at the furthest extremes, some sentiment was detected to move rating rules more toward the middle (that is, to tighten rating in the loosest states and loosen rating in the tightest states), but these sentiments were not strongly expressed nor consistent within each state. In states with very lenient rating limits, virtually no respondents indicated that there was any political support for more restrictive requirements, although a few of the respondents themselves thought such a change would be desirable. And in states that place tight limits on rates, we did not sense any groundswell for modifying these restrictions. (One exception may be the inclusion of groups of one—that is, the self-employed—in the small-group market. A number of observers felt that these groups should be rated separately from the rest of the small-group market because they believe that the self-employed tend to act more like individually insured people than larger small employers.)

In Maryland specifically, several respondents, including some agents and some insurance company representatives, indicated mild support for some loosening of the rating require-

ments. They suggested that such a change might cause insurers to offer lower premiums for young healthy groups and thereby increase the insurance participation among such groups. Doing so could help attract newer, start-up companies to the state, they suggested. On the other hand, virtually no one argued that such a change would substantially decrease the number of uninsured. Almost everyone acknowledged that permitting more rate variation would cause some higher-risk groups to be priced out of the market and agreed that the number of lower-risk groups that would be attracted would probably not be large, particularly in light of the major increase in overall premiums. Also, several agents complained that annual rate increases are especially high when members of a group cross into a new age bracket—a problem that is exacerbated when more rate variation is allowed for age.

Similar viewpoints were heard elsewhere. In states with moderate rating restrictions, some agents or carriers said they would favor loosening the restrictions somewhat, but none was confident this would have a big impact on the number or mix of employers deciding to purchase. Perhaps this lack of interest in change simply reflects a waning of the political salience of rating issues at this time when rates are rising so rapidly for virtually everybody. Or perhaps this reflects that a wide variety of rating approaches are compatible with well-functioning markets.

Impact on premiums and coverage

These muted and conflicting anecdotal views are consistent with more formal studies of the impact of rating reforms. Studies of various components of small-group market reforms indicate that these reforms as a whole have had only a small impact on overall prices or overall levels of coverage. Some studies indicate small positive effects, others indicate small negative effects, and others are unable to find any effects.[25] Most of these studies look only at the overall package of reform laws, not at rating reform in particular, and those that do focus on rating reforms usually do not measure the impact of different types of rating.

One exception is a recent report from the U.S. Government Accounting Office, which found that small-group rates in states that allow some rating for individual health status (beyond just demographics) were about 6 percent lower in 1996 than in states like Maryland with modified or pure community rating.[26] At the same time, the GAO found that community rating states do *not* insure a higher proportion of high-risk groups. This is counterintuitive, since the somewhat higher prices should result from drawing more higher risks into the market.[27] The researchers offered no hypothesis to explain why rates would be higher if more

[25] Sloan, F.A., Conover, C.F., and Hall, M.A. (1999): State strategies to reduce the growing numbers of people without health insurance. *Regulation*, 22.
[26] U.S. General Accounting Office, *Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage,* GAO-02-8, October 2001, p. 21-22.
[27] U.S. General Accounting Office, *Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage,* GAO-02-8, October 2001, p. 21-22.

higher-risk people are not included in the risk pool. There are several possibilities: (1) the GAO's measures of high risk groups may not be precise; (2) the finding of higher prices in community rating states may be spurious (that is, due to other factors such as underlying health care costs or coincidental willingness to buy richer benefits); or (3) community rating may be attracting only a few higher-risk groups but discouraging considerably more lower-risk groups from purchasing coverage, due to differing price sensitivity between high and low risks.

Until further studies are conducted, the GAO report should be considered only preliminary and tentative. For instance, another, more limited study, found that pure community rating in New York had no negative impact on the proportion of small groups with health insurance through 1996, compared to Pennsylvania which has no rating limits, and Connecticut which allows some rating for health risk.[28] Even if one is inclined to put more weight on one rather than the other of these studies, none of these studies shed light on the effect of different rating rules for demographics alone—for instance, not allowing gender rating, or allowing limited vs. full adjustment for age.

In theory, rating restrictions should cause rates to fall for higher-risk groups, causing more to buy coverage, and should cause rates to rise for lower-risk groups, causing some of them to drop coverage. The GAO study cited above includes data that sheds light on one part of the theory—the way rating rules affect premiums for groups of *varying risk.* Carried out by the National Association of Health Underwriters for the U.S. General Accounting Office (GAO), the study compared rates in five states with different rating rules (Maryland, New York, California, Florida, and Texas) for three 10-person fictional groups, with the second and third groups representing successively higher-risk conditions. (The second group included a person with juvenile-onset diabetes, and the third group included several people in their 50s, several smokers, women of childbearing age, and one member with juvenile-onset diabetes.) The results are shown in Table 5 below.

In Maryland, the rates were higher only for the highest risk group, up by 73 percent. Since New York has "pure" community rating, rates cannot vary for age, health status, or other factors; so the premiums do not increase as the risk of the group increases. In contrast, in Texas, premiums can vary over a range similar to Maryland's, but based on a greater number of factors, including industry and group size, but not health status; there, rates were 44 percent and 176 percent higher, respectively, as the risk of the group increased. Smaller increases, 6 percent and 85 percent, are shown for Florida. Maryland falls somewhere in the middle between New York and Texas: the rating laws result in higher premiums for the highest risk group but not by nearly as much as in Florida and especially Texas, where rating laws place fewer restrictions on insurers' ability to base rates on groups' risk. The state-by-

[28] Buchmueller, Thomas and J. DiNardo. "Did Community Rating Induce an Adverse Selection Death Spiral? Evidence from New York, Pennsylvania and Connecticut?" *American Economic. Review*, in press.

state comparison confirms the expectation that more restrictive rating rules produce lower rates for higher-risk groups.

Table 5: Average percentage change in premiums quoted for three hypothetical small employers with increasing risk characteristics in selected localities, 2000.

Location	*Average percentage change for group with one additional health condition*	*Average percentage change for highest-risk group*
Baltimore, Maryland	0%	73%
Albany, New York	0%	0%
Sacramento, California	0%	53%
Orlando, Florida	6%	85%
Austin, Texas	44%	176%

Source: U.S. General Accounting Office, *Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage,* GAO-02-8, October 2001, p. 20.

Impact of rating rules on insurers' willingness to do business in the state

The design of rating rules can also be judged according to whether they encourage insurers to enter a state or drive insurers away. It does not appear that rating rules, by themselves, have a large impact on carriers' willingness to enter or remain in a state. In all study states except Virginia, which has no restrictions at all on rate variation, we consistently heard that large numbers of carriers have left and the market is consolidating. As noted earlier, this appears to be a national trend unrelated to particular rating rules. In Florida, rating flexibility was added in 2000 specifically to attract more carriers, by allowing ±15 percent variation for individual health risk on top of full adjustment for age, gender, and location. No carriers have entered the state, and more have left. Both agents and carriers we interviewed in Florida complained that the new rules entailed substantially more work by requiring them to collect individual medical information, and no one thought this added flexibility helped to bring more healthier groups into the market. Some carriers are not using the flexibility in determining premiums, apparently deciding that the payoff is not worth the effort required to do medical underwriting.

One theme that emerged (in these interviews and in our previous work) is the following: more important than the particular rating rules is regulators' general attitude or practices in reviewing filings. Insurers look much more favorably on states that quickly approve filings without a lot of scrutiny, since this gives them the flexibility to quickly respond to marketplace developments. They are most critical of regulators that take a long time to respond or that micro-manage the details of rating factors, such as particular age slopes, family size

groupings, etc. These qualitative aspects of the regulatory environment appear more salient to insurers than the particular set of rating rules that apply.

A Comparison of Standard Plan Benefits

One major task of this study is to compare the benefits in Maryland's Standard Plan with those in Standard Plans in the other study states (New Jersey, Delaware, Virginia, North Carolina, Florida, and Colorado). The purpose is to determine whether Maryland's benefits are different to such an extent that the difference raises concern about the appropriateness of Maryland's benefit package. For example, if the comparison showed that Maryland's coverage was much more generous with respect to some expensive services, it would be appropriate to reconsider the appropriateness of that benefit level for those services and to determine whether reducing the benefit might make coverage significantly less expensive and, as a result, induce more small employers to purchase coverage. On the other hand, if Maryland's coverage seemed overly limited in some areas, this would be reason to consider whether an expansion of some benefits would be appropriate. Of course, simply finding that Maryland's coverage was significantly different from that in other states' Standard Plan would not justify a change. Decisions about which benefits to include rest in part on value judgments, and Maryland citizens may give somewhat different priorities to some benefits than is true of citizens in other states.

Before looking at the comparison, it is worth noting again that in only two of the study states—New Jersey and Colorado—does the Standard Plan account for a significant portion of small-group sales. In the other states, very few Standard Plan policies are sold. For that reason, in doing the analysis, we gave slightly greater weight to benefits in New Jersey and Colorado. It would be inappropriate to assume that the Standard Plan benefits in the other four states reflect the kinds of coverage that meet the needs of small employers in those states.

The table that follows arrays categories of benefits covered in Maryland's Standard Plan and shows the extent of the coverage for each category of service for both PPO and HMO coverage. The shading represents the comparison with Standard Plan benefits in other states. (It should be noted that while Colorado and North Carolina offer both a PPO and HMO plan as standard, New Jersey offers only a standard Indemnity plan, and Virginia and Florida offer only a HMO standard plan.) A white cell indicates that coverage is more generous in Maryland than is typical in the other study states. A gray cell indicates that Maryland's coverage for that service is similar to that offered in other states. And a black cell indicates that Maryland's coverage is less generous. (Appendix II shows coverage levels for all categories of services for Maryland and all the study states for those who wish to make more detailed comparisons.)

Table 6: A comparison of Maryland's Standard Plan benefits to Standard Plan Benefits in six other study states.

Color Code: More Comprehensive than Others | Similar to Others | Less Comprehensive than Others

	MARYLAND PPO		MARYLAND HMO
	In Network	**Out of Network**	
PLAN FEATURES			
Office Visit Copay	N/A	N/A	$20
Hospital Copay	N/A	N/A	$250
Hospital Coinsurance	80%	60%	N/A
Emergency Room Copay	$35 copay (waived if admitted)	$35 copay (waived if admitted)	$35 copay (waived if admitted)
Individual Deductible	$1,000	$1,000	N/A
Family Deductible	$2,000	$2,000	N/A
Individual Out-Of-Pocket	$3,400	$3,400	200% of annual premium
Family Out-Of-Pocket	$6,800	$6,800	200% of annual premium
Lifetime Maximum	$2 million	$2 million	N/A
COVERED SERVICES			
Physician Office Visits			
Routine Physical Examinations	80%	60%	$20 copay
Diagnostic Lab &X-Ray	80%	60%	lower of $20 or 50% of cost
Well Child Care/Immunizations	$10 copay	60%	$10 copay not subject to overall deductible for all in-network visits for children 0-24 months and for visits including immunizations for children 24 months to 13 years
Preventive Care	80%	60%	covered
Specialist (Office Visits)	80%	60%	$30 copay
Outpatient Diagnostic Services (Diagnostic, Laboratory and X-Ray)	Greater of $20 copay or 80% coinsurance	Greater of $20 copay or 60% coinsurance	lower of $20 or 50% of cost
Outpatient Surgery	Greater of $20 copay or 80% coinsurance	Greater of $20 copay or 60% coinsurance	$20 copay
Outpatient Rehabilitation Physical Therapy Occupational Therapy Speech Therapy	Greater of $20 copay or 70% coinsurance; 30 visit limit	50% coinsurance; 30 visits limit	$20 copay or 70%; 60 day limit
Professional Fees - Inpatient Surgeons/Physicians	80%	60%	$20 copay
Maternity Care Physician Prenatal and Postnatal Care	80%	60%	covered
Emergency Care			
Hospital Emergency Room Care	80%	60%	covered - $35 copay (waived if admitted)
Ambulance Services	80%	60%	covered
Durable Medical Equipment	80%	60%	covered, including nebulizers, peak flow meters, and diabetes glucose monitoring equipment
Home Health Care	80%	60%	covered as an alternative to otherwise covered services in a hospital or other related institution
Hospice Services	80%	60%	covered

	MARYLAND PPO		MARYLAND HMO
	In Network	**Out of Network**	**In Network**
Hospice Services	80%	60%	covered
Skilled Nursing/Extended Care Facility Services	Greater of $20 copay or 80% coinsurance; 100 day limit	Greater of $20 copay or 60% coinsurance; 100 day limit	$20 copay; 100 days as alternative to otherwise covered care in a hospital or other related institution
Infertility Services For the Diagnosis And Treatment Of A Medical Condition	50% (excludes in vitro fertilization)	50% (excludes in vitro fertilization)	coverage for services obtained after diagnosis of infertility, 50% coinsurance rate of allowable charges (excludes in vitro fertilization)
Transplant Benefit Coverage for Transplants	80%; bone marrow, cornea, kidney, liver, lung, heart, lung/heart, pancreas and kidney/pancreas	60%; bone marrow, cornea, kidney, liver, lung, heart, lung/heart, pancreas and kidney/pancreas	coverage for bone marrow, cornea, kidney, liver, lung, heart, heart/lung, pancrease and pancreas/kidney
Mental Health/Chemical Dependency			
Inpatient - Mental Health	70%	50%	covered when delivered through carriers' managed care system for 60 inpatient days with partial hospitalization traded on a 2 to 1 basis
Outpatient - Mental Health	70%	50%	covered when delivered through carriers' managed care system - unlimited for outpatient visits subject to following cost sharing: in-network carrier pays 70%; out-of-network carrier pays 50%
Inpatient - Chemical	70%	50%	covered when delivered through carriers' managed care system for 60 inpatient days with partial hospitalization traded on a 2 to 1 basis
Outpatient - Chemical	70%	50%	covered when delivered through carriers' managed care system - unlimited for outpatient visits subject to following cost sharing: in-network carrier pays 70%; out-of-network carrier pays 50%
Prescription Drug Services Retail Pharmacy (34-day supply)			
Retail Generic	$250 separate deductible; $15 copay	$250 separate deductible; $15 copay	$250 separate deductible; $15 copay
Retail Brand	$250 separate deductible; $20 copay	$250 separate deductible; $20 copay	$250 separate deductible; $20 copay
Formulary	$250 separate deductible; $20 copay	$250 separate deductible; $20 copay	$250 separate deductible; $20 copay
Non-formulary Brand	$250 separate deductible; $30 copay	$250 separate deductible; $30 copay	$250 separate deductible; $30 copay
Pre-existing Condition Limitations	None	None	None

In general, Maryland's Standard Plan Benefits do not seem far out of line with those of others states. There are some differences, however:

PPO

- The Maryland PPO plan deductibles and out-of-pocket maximums are higher than those in the other states.
- The coinsurance level (in network 80 percent paid by the plan) is also less generous than most states.
- The mental health and substance abuse benefits are more generous than most states.
- The emergency room copayment is more generous than most states.
- The lack of any preexisting condition limitation is more generous.
- The separate $250 prescription drug deductible with copayments is, for the most part, better than plans with a 50 percent benefit (for those with high drug costs, that is, those with costs exceeding $250 per year) but less generous than plans with no separate deductible.

HMO

- The plan copayments are less generous than all the other states.
- The separate $250 prescription drug deductible is less generous than all other states.
- The emergency room copayment is more generous than most states.
- The mental health and substance abuse benefits are more generous than most states.

Later in this report, we discuss the policy implications of these findings.

Though not required for the study, we also compared the Maryland Standard Plan benefits to plans identified by several Maryland carriers as their most popular plan. Such a comparison helps in understanding the differences between the Standard Plan benefits and what small employers actually purchase. What we found was that small employers are selecting plans with low fixed co-payments and no deductibles for care provided in-network. Plans also typically eliminate the separate prescription drug deductible. Finally, consumers are purchasing plans that provide a higher health plan coinsurance rate and lower deductibles for out of network benefits.

THE POLICY OPTIONS

Preamble to policy options: how premium reductions would affect the number of people covered

In requiring that this study be undertaken, the legislature can be presumed to have been asking whether changes in the Standard Plan benefits or changes in Maryland's premium rating restrictions could bring about an increase in the level of coverage among small employers without creating other undesirable consequences. The purpose of such policy changes would be to reduce the cost of coverage, under the assumption that lower health insurance premiums would cause more employers to offer coverage and more employees to accept such coverage. To some degree, that assumption is surely correct. Lower prices would bring some employers and their employees under the insurance umbrella. But the important question is to what *degree* would premium reductions increase the rate of coverage. Several recent studies provide evidence that help answer this very important question. Unfortunately the findings are not encouraging.

The Center for Studying Health System Change issued a report in December 2001 that indicates that even very large premium reductions would produce only small increases in the number of small-firm workers who would be covered.[29] According to this analysis of firms with fewer than 50 workers, a 30 percent reduction in premium costs—far larger than what could be expected from any feasible changes in small-group reform rules—would induce only 15 percent of currently uninsured small employers to offer coverage.[30] The proportion of newly insured *workers* would be even less, for two reasons. First, a large portion of the workers in uninsured small firms, 59 percent nationally, already have access to health coverage from some other source and presumably have already made a decision to either buy or not buy coverage. Second, a significant number of those who have no coverage would decline their employer's offer—about 20 percent, according to this study. If we assume these findings would apply to Maryland, a 30 percent reduction in premiums for small-group employers would result in about a 5 percent reduction in the number of uninsured workers in previously uninsured small firms (15 percent newly insured employers x 41 percent of employees not previously offered coverage x 80 percent of employees who would accept coverage = 4.92 percent). Of course, some of the uninsured workers in firms that already offered

[29] James D. Reschovsky and Jack Hadley, "Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly," Issue Brief: Findings from HSC, No. 46, Center for Studying Health Systems Change, December 2001.

[30] In technical terms, the research concluded that the premium elasticity of demand of small establishments is 0.54. Price sensitivity is greater for the smallest small firms. For a more detailed exploration of small firms' price sensitivity see the same authors' technical article "Small Firms' Demand For Health Insurance: The Decision To Offer Insurance." to be published in *Inquiry* in 2002.

coverage—55 percent of all small firms in Maryland—would elect to purchase coverage because of the now-lower premium. So the net positive effect would be somewhat larger.

A second recent study, by M. Susan Marquis and Stephen H. Long,[31] found that small employers (defined in their research as firms with fewer than 100 employees) were even less responsive to premium reductions. These researchers concluded that for small employers as a whole, a premium reduction of 40 percent would cause the proportion offering coverage to increase by slightly less than 5 percent. That is, the probability that small firms would offer coverage would increase from 51.5 percent to 54.0 percent (2.5 points, or a 5 percent increase) if premiums fell by 40 percent. Low-wage small firms are somewhat more responsive to premium reductions. For them, a 40 percent premium reduction could be expected to increase the proportion offering coverage from 27.9 percent to 31 percent, an 11 percent increase.[32] Again, because not all workers newly offered coverage would accept, the proportion of newly insured workers in these firms would be substantially less.

A third study, to be published in 2002 in the *International Journal of Health Finance and Economics* by Linda J. Blumberg, Len M. Nichols, and Jessica S. Banthin, also finds that uninsured workers in small firms are very insensitive to changes in premium prices. In other words, they conclude that it would take large premium reductions—particularly in the portion of the premium that employees are required to pay out of pocket—to bring about a significant increase in the number of these workers who would choose to accept employer-sponsored coverage if it were offered to them.

These researchers (and others not cited) come to similar though slightly different conclusions regarding the degree of sensitivity of small employers and their employees to the costs of providing health coverage for their workers. *But there is strong agreement that even large reductions in premiums would produce only modest increases in the number of people covered. This means that small reductions in premiums—of the magnitude that might be affected by altering insurance reform rules—will do little to increase the number of insured workers in small firms.*

These findings suggest that it would be unrealistic to expect that incremental changes in Maryland's rating rules or the benefits in the Standard Plan could affect premiums sufficiently to cause significant numbers of uninsured workers to be covered. Large changes might produce modest increases in coverage, but this would necessarily come at the cost of compromising other policy goals, such as affordable comprehensive coverage for higher risk small groups. If the objective is to reduce the number of uninsured people in Maryland without harming other health policy objectives, this research evidence makes the consideration of changes in policy somewhat moot. On the other hand, a somewhat encouraging cor-

[31] M. Susan Marquis and Stephen H. Long, "To Offer or Not to Offer: The Role of Price in Employers' Health Insurance Decisions," *HSR: Health Services Research,* Vol. 36, No. 5, October 2001, p. 946.
[32] In technical terms, Marquis and Long report the following price elasticities of demand for small employers. For all small employers, -0.14; for employers with low-wage workers, -0.25; for other small employers, -0.12. (p. 947.)

ollary of this generally discouraging research is that increases in premiums of relatively large magnitudes (like those that many small employers are presently being asked to absorb) are not likely to cause many small employers to drop coverage. The relative insensitivity to health insurance price changes works in both directions.[33]

Reconsidering the functions of the Standard Plan

Even though the research on price sensitivity suggests that changes in the Standard Plan benefits would have little effect on the number of uninsured, it is still worth reconsidering the role and function of the Standard Plan and the options for change. The state could change its policy with respect to the Standard Plan in six possible ways:

1. Eliminate the requirement that insurers offer only the Standard Plan and let the market decide.
2. Have more than one Standard Plan, with some having less comprehensive benefits.
3. Allow riders that reduce benefits.
4. Alter the "floor" or "ceiling" requirements, which tie the benefits at the bottom to the actuarial equivalent of benefits offered by a federally qualified HMO and at the top to 12 percent of the average wage.
5. Make benefits less comprehensive. The state could eliminate some benefits to bring down the minimum cost.
6. Increase cost sharing.

We consider a number of these policy options in the general discussion concerning the functions of the Standard Plan. The issue of what benefits should be included in the Standard Plan is a different issue from the consideration of the function of the Standard Plan. We will consider that issue separately.

In 1993 the Maryland legislature required insurers to offer the Standard Plan as part of a comprehensive package of small-group market reforms. Given the passage of time since reforms were originally implemented in July 1994, it is appropriate to ask whether this particular element of market reforms is still worth maintaining. Should the Standard Plan be eliminated entirely, or at most, should it be an option that insurers are required to offer but with no limit on what other options they offer?

Most people who have considered market reforms in Maryland and elsewhere would agree that the most important innovations were the regulations requiring that coverage be offered on a guaranteed-issue and guaranteed-renewal basis, that portability be guaranteed, that pre-

[33] Another corollary is that subsidies to small employers would have to be large to induce many to offer coverage anew, although the research indicates that subsidies to low-wage employers would produce greater "take-up" rates than those given to all small employers. Another implication is that subsidies provided directly to uninsured workers are likely to be more cost-effective than subsidies to small employers.

existing condition limits be restricted, and that rate variation based on risk be limited. In many states, these requirements originally were applicable only to the Standard and Basic plans. But HIPAA changed that (except it did not affect rating rules), and as a consequence, the Standard Plans have little relevance in most states. The question is whether the usefulness of the Standard Plan is limited in Maryland as well.

Ensuring adequate benefits

One function of the Standard Plan is to serve as a benefit floor to ensure that people get at least a minimum level of coverage, comparable to what larger employers are able to offer. Small employers may not have the resources or expertise to consider carefully what is an adequate benefit package, and the Health Care Commission, by deciding and regularly reconsidering what should be in the Standard Plan benefit package, relieves them of that burden and in the process protects consumers from buying inadequate coverage. But that function may not be necessary. Experience in other states shows that most small employers want and purchase quite comprehensive coverage, similar to what large employers buy. "Bare bones" plans do not sell well, so the fear that large numbers of small employers would choose inadequate coverage in the absence of the Standard Plan mandate seems unfounded.

On the other hand, if employers want to buy less comprehensive coverage, why should they not be able to do so? After all, the state could give guidance to small employers about an adequate benefit package simply by requiring insurers to offer the Standard Plan *as one of any set of options they choose to offer*. Why should the market not decide these issues, just as the market is left to decide most economic issues?

Addressing that reasonable question requires a consideration of the function of mandated benefits (which is, of course, what the Standard Plan is). A major reason for supporting mandated benefits is that when benefits are mandated, the costs are spread over the whole insured population, making the cost per insured person small. For example, without the Standard Plan (or other forms of mandated benefits) some small employers would not cover maternity care, particularly those with few employees of child-bearing age. Without the maternity coverage mandate, the smaller number of employers who would want that coverage—those who have employees that expect to need maternity benefits—would pay a much higher price because the costs would not be widely shared by the employers who have few employees that would use the benefit. These increased costs might cause employers to drop coverage of those benefits or engage in employment discrimination against those with high health costs. The benefits of spreading the cost through mandates are even stronger for benefits that are used by only a small fraction of the insured population—for example, habilitation services. Whether that cost-reduction result justifies mandates is a value judgment—one that the legislature has apparently often made on the side of imposing mandates.

Ensuring affordability

Another function of the Standard Plan is to provide a "ceiling" on the cost of an appropriate benefit package—that is, to ensure affordability. The Health Care Commission is required to alter the elements of the Standard Plan, if necessary, to ensure that the average cost is no greater than 12 percent of the average wage. If there is a danger that the cost ceiling will be exceeded, the Commission has to reconsider the benefit package to decide what tradeoffs to make between cost and coverage to best meet the needs of small-firm workers and their families. The idea is that during periods of cost escalation, the Commission, with the specific assignment to consider the tradeoffs, is more likely to come up with an optimum mix of benefits than would individual small employers trying to make that calculation on their own. In other words, the Commission has to consider what mix of benefits provide the optimum value given the 12 percent affordability constraint.

While there is considerable logic to this argument, it is weakened somewhat by two facts: (1) When faced with cost pressures, the Commission has typically increased consumer cost-sharing rather than cutting specific benefits. (2) Virtually all small employers add riders to make the coverage more comprehensive, usually by reducing the cost-sharing, which suggests either that they are willing to pay more than the legislated ceiling or that the Commission has not made decisions in choosing benefits and cost-sharing that match what small employers would make on their own. That is, employers might prefer that the Standard Plan include more generous coverage for some items (for example, lower deductibles on drug coverage, which is observable from what they buy) and less generous coverage on some other items that they would choose not to buy if they had that option (which is not observable, since employers do not have that option).

Finally, it has to be said that a ceiling of 12 percent of average wages or any other figure is an arbitrary (though not necessarily unreasonable) limit. Some have argued that since the cost of the Standard Plan without riders has always stayed well below 12 percent, that the figure should be lower to put more pressure on the Commission to make tradeoffs to ensure affordable coverage. On the other hand, it could be argued that since employers buy riders to go beyond the benefits in the Standard Plan, the "right" figure—that is, a figure that represents employers' preference—might be higher.

It is also worth noting that the 12 percent ceiling requirement has a conceptual flaw. The legislature presumably imposed this cap as a test of affordability, but it will not serve that function well if there is a shift in the number of family members covered per insurance policy. The average premium—and thus whether the cap is met—depends crucially on whether people are buying single coverage, single plus dependent, or family coverage. To illustrate, according to MEPS data, the average single person policy is only about 8 percent of annual pay in Maryland, whereas family coverage is about 19 percent. (Although these statistics are not identical to those used for calculating the affordability test in Maryland, they are simi-

lar.) It is obvious that if large numbers of insured people were to shift from single to family coverage—which presumably would be a desirable change—the average premium per employee would rise, and the legislature's premium cap might be exceeded even though no change had occurred in the affordability of coverage. The Health Care Commission would then be required to reconfigure the benefits and cost sharing in the Standard Plan, even though that would presumably not be consistent with the legislature's intent.

This is a significant potential problem in the other direction in times of rapid premium escalation. The consensus view is that at such times, employers tend to reduce their contribution for dependents, making it more expensive for workers to cover their families. Under such circumstances, employees tend to drop dependent coverage. But this reduction in the affordability of coverage would not necessarily show up as an increase in the cost of the average premium, or at least would not be fully reflected. The Commission might not see any need to adjust the Standard Plan benefits even though the affordability of coverage had declined significantly.

The Commission is aware of this problem and tracks the data on the number of people covered per policy. A significant change in the statistic would be cause for further investigation. It would probably also be useful for the Commission to track the change in the cost per *covered life* relative to the change in the annual wage. If this statistic is changing in a way that is significantly different from the cost per employee as a percentage of the annual wage, the implications for affordability should be carefully considered.[34]

Resisting benefit mandates

Another argument has been made for retaining the Standard Plan in combination with the cost ceiling. Since the Standard Plan is exempt from the benefit mandates the legislature imposes for other insured products, the ceiling requirement gives the Commission the responsibility and thus the political "cover" to resist the addition of mandated benefits that might make coverage unaffordable for some small employers.

[34] In requiring that the price of the Standard Plan not exceed 12 percent of the average annual wage, the legislature was obviously concerned about making coverage affordable for people working in small firms. Maryland has recently implemented several programs to help make coverage more affordable for low-income families, many of whom have wage earners employed by small firms. Maryland Children's Health Program provides coverage for children under the age of 19 for such families. Eligibility is based on income and family size. For example, families of four whose income falls below $35,300 are eligible. In addition, under the MCHP *Premium* program, a working family of four that has income below $52,950 is eligible for subsidies to help pay for the cost of employer-sponsored coverage available through a parent's employer. The availability of these subsidies obviously helps to keep the cost of family coverage to a manageable proportion of income for low-income families and helps to achieve the legislature's purpose for imposing the 12 percent cost cap.

Simplifying choice and encouraging competition

A final important argument for having the Standard Plan is that it simplifies the choices that employers face in deciding on coverage and also makes it possible for them to meaningfully compare the value of competing insurers' offerings. No one can accurately assess the cost and benefits differences among dozens of plan offerings. (Prior to reform, in some states the plan offerings numbered in the hundreds.) And no one can make a convincing argument that offering employers dozens of plan options is really necessary to give them adequate choice. Limiting choice to some degree seems reasonable. Requiring all insurers to sell the Standard Plan has the additional important advantage, at least in theory, of allowing employers to make benefit-value comparisons among different carriers. Since the benefits are standardized, employers can compare insurers on just price and service level differences, a manageable calculation. The extension of the argument is that, knowing that customers can compare carriers for value differences, the competitive pressures on carriers to provide good value will be greatly increased, thereby encouraging greater efficiency and higher levels of service.

Of course, the reality may not always match the theory. Though not required to do so by law or regulation, the Maryland Insurance Administration periodically (typically, two times per year) publishes rate comparisons for small-group coverage (for a fictional small-employer group). One function that this rate guide serves is to give small employers a basis for comparing prices of the various carriers.[35] In addition, agents are supposed to inform employers of the price of the Standard Plan without riders. Neither of these practices seems particularly effective in accomplishing the purpose of alerting consumers to plan-to-plan price differences and inducing them to act on them. One of the fundamental conditions that economists agree must be met for markets to be competitive and to work successfully is that consumers must have access to accurate information about prices and the character of products. The current practice of publishing the Standard Plan prices is consistent with this proposition, and making such information available is an appropriate function for government. But by itself, it does not fully meet the condition of providing the information small employers need.

The consensus among our informants is that most consumers are unaware of the price comparisons published by the Maryland Insurance Administration. Further, they agree that employers often do not see or do not pay attention to the price of the Standard Plan without riders because that is not what they buy and because the composition of the fictional group does not match the composition of their work force. When they talk to agents and brokers, employers want to know what it will cost to retain whatever coverage they had previously, which usually includes riders.

[35] Another purpose is to let employers know what carriers offer coverage and how they can contact the carriers for more information.

The lack of attention by consumers does not necessarily mean, however, that the rate guide is ineffective in promoting competition. If *insurers* pay attention to the published price comparisons, and if they want to avoid appearing as being out of line with their competitors, the purpose of encouraging price competition may be well served. At least one major insurer in Maryland, according to a representative from that company, regularly looks at the published price list to ensure it does not appear as a high-cost company and, in fact, on at least one occasion lowered its price for the Standard Plan after reviewing the published price list.

The anecdotal evidence suggests that more vigorous efforts should be taken by the state to make sure that employers and the public generally are aware of the price comparisons for Standard Plan coverage. The present form in which this information is published may not be most suited to promoting an effective market, which requires (1) giving employers an indication of the comparative prices of different carriers' offerings, (2) putting pressure on carriers to engage in vigorous price competition by publicizing the price differences. Under present practice, the Maryland Insurance Administration requires carriers to give premium quotations for a fictitious group of 10-employees of varying ages. What the carriers supply in response is monthly premiums for four categories of coverage—single, individual and spouse, individual and dependent, and family—assuming the average employee age of the fictitious group. In its present format, it is not easy to understand what the data show. Since quotations are provided for indemnity, PPO, HMO, and POS coverage, as well as for four areas of the state, this amounts to a very large number of data elements (416 for the publication giving rates for July 1, 2001, for example). It is not surprising that employers do not pay much attention to this or that reporters' may not use this data as a basis for writing stories to inform people of costs differences among health plans. There is just too much data for most people to absorb and understand. The information would be useful if it were put in a form that is more readily understood and accessible, including a more careful explanation of how to interpret the data.

In our view, the information would be more useful and easier to understand if the guide prominently featured a single premium for each carrier *for the fictitious group as a whole* for each type of plan offered. (To make the group representative of what small employers might buy, the Maryland Insurance Administration would have to assign more characteristics to the group—specifically, in addition to having people of different age, some employees should be specified as having single coverage, others family coverage, and others coverage for individual and spouse, etc.) And the data would probably be more meaningful if it were grouped in a way that highlights the rates of carriers that account for a significant share of small-group business.[36] In other words, care should be given to present the cost comparisons in a way that creates the greatest possible impact in terms of increased attention and improved understanding by small employers and the public in general. We believe that the Maryland Insur-

[36] For example, the report might highlight the rates of the carriers that the Health Care Commission identifies as "prominent carriers."

ance Administration should continue to make available the level of detail that is available now, but this information should be put in an appendix and continue to be made available on the website rather than being prominently displayed in the material that goes to the public. The objective here is not to alter the intent or function of the price guide but to communicate the salient information more effectively.

We recommend that the Maryland Insurance Administration, in consultation with the Health Care Commission, take actions to ensure that the Standard Plan price comparisons (published as the "rate guide") are more understandable, useful, and widely publicized. Consideration should be given to changing the form in which the premium quotations are submitted and the way they are summarized in the public presentation to make the information simpler, more meaningful, and more accessible (as outlined above). To increase visibility of the information, at a minimum the Maryland Insurance Administration should issue a press release at the time of publication and make certain that key health and consumer reporters have the opportunity to talk to relevant public officials regarding the significance of the published price information.

Another difficult puzzle is how to ensure that employers know about the purpose and function of the Standard Plan, as well as the price at which it is available from various carriers. There is a requirement that agents provide that information, but the consensus is that the information is often not presented at all or not presented in a way that captures the attention of employers. **We recommend that the Maryland Insurance Administration, in conjunction with the Health Care Commission, reconsider how to most effectively implement the requirement that insurers inform employers about the Standard Plan. The objective should be to determine what is the most effective way to ensure that insurers prepare and supply to potential customers information that includes a description of the purpose, function, and benefits of the Standard Plan, including the explanation that the benefits represent the Commission's judgment of the optimal mix of benefits given the budget constraint under which the Commission operates in establishing the benefits.** One way to enforce the requirement would be to require agents and brokers to get the employer's signature attesting to the fact that the employer has been shown and has read prescribed information. We think this approach deserves consideration, but we stop short of recommending it because we are not fully convinced that it would have the desired effect. It might be simply a requirement that is followed on a pro forma basis and seen merely as an annoyance by both agents and employers—yet another piece of paper to sign.

Should the Standard Plan have more flexibility?

The functions that the Standard Plan is intended to serve provide a convincing case for retaining the Standard Plan, but it may be that these functions can be served while still pro-

viding more flexibility. This raises two additional questions: (1) Should Maryland consider having several Standard Plans (as New Jersey does), or (2) should the state allow "negative" riders that permit employers to "subtract" from some of the benefits in the Standard Plan (again, as New Jersey does)? There is some merit to both of these positions. The multiple Standard Plan approach would allow employers greater flexibility in choosing among "approved" benefit packages without forcing them to deal with an unmanageably large set of plans from which to make a selection. The "negative" rider approach provides similar, though less constrained, flexibility. Either approach would still allow the Commission to serve the function of informing small employers about their judgment of what constitutes an appropriate benefit package, though that objective might be somewhat diluted if there were multiple Standard Plans. And the cost ceiling function might be lost with the multiple plan option.

The disadvantage of these approaches is that they create the strong possibility that risk pooling will be diluted. If there are multiple Standard Plans with different benefit packages (as opposed to different cost-sharing provisions), employer groups are likely to separate themselves out according to their judgment about their employees' need for particular benefits. People who anticipate needing services covered in one Standard Plan but not others will select that plan. People who do not expect to use particular covered service will choose a Standard Plan that excludes them. The result is that employers with younger, healthier workers will tend to choose a plan with leaner benefits, and those with workers more likely to need extensive services will more often choose more comprehensive coverage. Risk spreading could be reduced, and the cost of comprehensive plans could rise much more rapidly than the cost of leaner plans. Fear of this risk segmentation and dissolving of the risk pool is the reason that New Jersey, which does offer multiple Standard Plans, decided that the plans should differ only with respect to the amount of consumer cost sharing, which, for the majority of plans sold, applies only to out-of-network services. Health purchasing cooperatives, which also typically offer multiple standard plans, have usually decided that the plans should differ only with respect to cost sharing, for the same reason. A similar risk segmentation problem could occur if employers had the option of attaching negative riders: employers whose workers were less likely to need certain benefits would choose to "rider them out," creating the same kind of risk segmentation and cost problems just described. This is one reason New Jersey allows negative riders for only certain benefits; coverage for others cannot be excluded through riders.

On balance, we conclude that the Standard Plan serves a useful purpose and that because riders are permitted, it does not unduly limit small employers' flexibility in choosing benefits that best meet their employees' needs. While there is merit to allowing employers to opt for benefits that are less comprehensive than the current Standard Plan, we think that the dangers of risk segmentation are sufficiently great that such a change—whether done through negative riders or several Standard Plans—should be approached with caution and limited

primarily to broad cost-sharing features of the plan. On the other hand, we recommend that if the Commission is faced with the need to make changes in the Standard Plan to stay within the cost ceiling, that they give more serious attention to altering *benefits*, and not just increasing cost-sharing. The current approach to some degree abrogates the responsibility to make tradeoffs, that is, to decide which mix of benefits is optimum given the 12 percent constraint, particularly since the typical response of employers has been to add riders to restore the cost-sharing provisions to what they were before the Commission's change. Unless the Commission reconsiders the benefit mix during times of cost escalation, the justification for having only one Standard Plan is substantially weakened.

In fact, we recommend that the Commission go further. Especially in times of cost escalation like the present, when coverage is becoming less affordable, what small employers need is an answer to the following question: "If I have only so much to spend for health coverage for my employees, what combination of medical service coverages and cost-sharing provisions will provide the best possible protection for the money?" The benefits in the Standard Plan should provide the answer to that question, and the Health Care Commission should employ its collective experience, expertise, and knowledge to ensure that it does.

In determining the Standard Plan benefits, we recommend that the Commission use the approach that in public administration circles is referred to as "zero base budgeting." Instead of approaching the question of what to include in the Standard Plan benefits in an incremental way—that is, by deciding what should be added or subtracted from the present benefit package—we recommend that at least every five years, the Commission *start anew* and decide, without any preconceived judgments, what package of service benefits and cost sharing represents the optimum value given changes in medical technology, shifting relative costs, employers' actual buying patterns, consumer preferences, etc. In taking this approach, we recommend using 10 percent of the average wage as the budget constraint, which would leave some room both for future cost escalation (and thereby not require an immediate reconfiguration of the benefit package) and would allow employers to add riders and still keep the total average cost within the 12 percent limit (which, though not required by the legislation, has been the actual practice).

Completely rethinking the benefits package every five years will not be an easy task, and we recognize that it is fraught with political and practical difficulties. But the fact is that as medical technologies change and public preferences and expectations evolve, the ideal benefit package will change also. And the Standard Plan should reflect these changes if it is to be most useful to small employers. The Commission, because of its legislatively established independence of the political process, is well positioned to make the necessary decisions on an objective basis. Saying that the Commission should start with a clean slate every five years does not mean that the Commission must go through the same lengthy and politically charged procedure that was followed in devising the benefit package initially. Instead, the

Commission could do an internal assessment, calling on whatever resources it felt useful, including consultation with the business community and experts in public health and health economics, and then, using its independent judgment, come up with a new proposed benefit package. In essence, the process could be very similar to the one the Commission employs currently in deciding on changes. The difference would be in the range of benefit changes that would be considered. The new proposed package would then be subject to the usual review and public comment procedures, etc. The result might be a benefit package that is not dramatically different from the preceding one, but at least there would be the assurance that benefits were not included or excluded just because that was the way it had always been done in the past. Adopting this recommendation does not require giving the Commission any new authority; instead, it simply requires the Commission to do what it presently does in a slightly different way.

In deciding what benefits and cost sharing to include, the Commission might take the following approach. First, consider what benefits are necessary to protect people from incurring large, unpredictable losses—the traditional insurance function. Second, consider what benefits are essential for health maintenance and prevention of disease, even if the expected expenses are neither unpredictable nor large. The objective here is to ensure that people not be deterred from accessing care that may substitute for more expensive care later on. Coverage for prescription drugs might fall into this category, for example. This represents the prepayment component of health coverage. Third, bring the coverage as closely as possible into line with employers' and employees' preferences for coverage, as perceived by observing what kinds of coverage they most commonly buy. In particular, an effort should be made to keep cost sharing components of the standard plan at levels that resemble what is most commonly being purchased in the market. (This last step would be more difficult to accomplish if the Commission were to try to set the cost at 10 percent of the annual wage, as suggested earlier.)

If the Commission adopts this approach, it would be worth considering a modest change in the Standard Plan, specifically, to have a single Standard Plan with respect to covered medical services but allow negative riders that are *restricted to only cost-sharing features of the plan*. Thus, the same standard set of clinical areas would be covered in all plans, with a standard structure to plan benefits. However, employers who wished to offer a leaner package could do so by increasing deductibles, co-insurance, or co-payments for broad categories of coverage (for example, hospitalization, physician services, prescription drugs). This is similar to the current approach, except under this arrangement, the cost-sharing features of the Standard Plan could be set at levels that more closely match what is commonly sold in the market, with variation through riders in *both* directions, rather than setting cost sharing at an unusually high level, which requires most employers to purchase riders that lower these levels. Doing this would make the Standard Plan a more useful benchmark both for overall market performance and for comparing prices between competing insurers.

This approach has the merit of having the Standard Plan more nearly match what employers actually buy, while also allowing them more latitude than they now have in deciding what benefits level to offer. It would also allow employers who want to experiment with the medical savings account approach to take that step. Moving toward this approach would require the Commission to decide whether there should be limits on the amount of cost sharing that benefit plans can include or the deductibles they can impose for particular categories of services. We think that there should be limits of this sort to prevent insurers and employers from effectively excluding coverage for certain categories of services, which, among other things, is likely to produce risk segmentation. On the other hand, the argument for prohibiting large deductibles for all or most services in combination is weaker. There is little evidence that this would cause problems. High-deductible plans are not popular with employers and employees. For example, nearly all small employers in Maryland now buy coverage to reduce the cost sharing in the current Standard Plan benefits. Moreover, when such plans have been offered across the country, the number sold has been small. Although the theoretical arguments for this kind of coverage are strong, the reality is that employees generally do not want coverage that requires them to bear high front-end costs, and employers buy coverage because they want to attract and retain good workers. But the fact that high-deductible plans do not sell well does not seem sufficient reason to prohibit employers from offering them, particularly since employers are not required to provide any coverage if they choose not to.

Policy implications of comparison of benefits in Maryland's Standard Plan to those in other states

As reported earlier, some of the benefits in Maryland's Standard Plan vary in modest ways from those in others states. In the detailed discussion above we have already outlined an approach to revising these benefits in the future. As the Commission already knows, the consideration of benefits has to be an ongoing process, and the decisions have to reflect Maryland values, which may differ from those of other states.

In doing the comparison, we did not think it useful or practical to try to compare benefits at a very fine level of detail, and our comments are not at that level. We offer the following observations for the Commission to consider when it reassesses the benefits in the Standard Plan. As already noted, the PPO plan deductible and out-of-pocket limits are high relative to other states. The emergency room copayment and mental health/substance abuse benefits are more generous than in most of the study states and are somewhat out of line with the direction the market is going; so the Commission may wish to consider modifying the benefits in the direction of being somewhat less generous. The lack of any preexisting condition limitations is different from most states. Because we know that the policy on preexisting condition reflects a strongly held view in the state that restrictions on access to coverage should be

minimal, we do not recommend any change in the overall policy if Maryland makes the changes we recommend with respect to "groups of one" (described below). It is these groups of one that pose the greatest danger of adverse selection when there are no pre-existing condition limits. Individuals can predict when they need care and wait to buy coverage until that time; for larger groups this strategy is more difficult to follow. But our recommendations related to groups of one would help to mitigate this problem.

While the HMO benefits in the Standard Plan are somewhat less generous than in the other states we reviewed, we do not recommend changing them. The copayments required by the Maryland plans are in line with where other states and the commercial employer market are moving.

Changing the rating rules

As shown earlier, Maryland's rating rules allow less variation from group to group than is true in many other states. In this section, we consider whether it would be advisable for the state to alter those rules in an effort to entice more small employers to buy coverage. Maryland could alter its rating rules in any one of the following ways:

1. Leave rating factors unchanged but allow more variation for age and location.
2. Allow variation within prescribed limits for other easily observable factors such as group size or industry classification.
3. Allow unlimited variation for age and location as long as actuarially justified but nothing for health status
4. Allow variation for individual health status or group claims experience, but within prescribed limits.

Before turning to these alternatives, we need to recall that the research evidence suggests that rating reforms have not had a major impact on premium prices or on the number of people who are covered. The predictions of the early opponents of rate reform that premiums would rise drastically and that large numbers of young, healthy workers would drop coverage proved unfounded. Similarly, the hope of the reform supporters that large numbers of new groups who previously found insurance affordable would be drawn into the market seems also not to have been realized. Within the range of rating reforms that exist in the country, there is no clear-cut evidence that there is a close relationship between how well the small-group market operates in a state and the kind of rating reforms that apply. Given the other small-group reforms in place, reasonably well-functioning markets seem compatible with considerable variation in rating laws. This does not mean that rating reforms have had no benefit. Higher-risk people have been protected against having to pay unaffordably high rates. Agents, for example, consistently say that they are greatly relieved not to have to tell some small employer that their rates are going to increase drastically because some employee in the group developed a serious medical condition.

These observations lead us to the following recommendation:

With one exception related to so-called "groups of one," we recommend that Maryland not change its rating rules that limit insurers' ability to vary premiums based on a group's characteristics.

We offer the following justifications for this recommendation.

First, most observers we spoke to in Maryland believe that the present rating rules and other small-group reforms are working well. The consensus is—and it is one with which we agree—that the problems that the state is experiencing, most notably high premium increases and a reduction in the number of carriers operating in the small-group market, are not significantly related to the small-group reforms and that changing the rating laws would not solve these problems.

Second, while Maryland's rules are somewhat more restrictive than the other study states except New Jersey, we do not believe that making the rules more lenient would achieve the desired result of appreciably increasing the number of small employers who offer coverage and the number of employees who take up coverage. The research shows that small employers and their employees are so insensitive to changes in the price of health coverage that any reduction in price for lower-risk employers that could be achieved through tweaking the rating laws would have very little effect on the number of employees who are covered. It is highly unlikely that any changes in rating rules that Maryland would consider would cause premiums for lower-risk groups to decline by more than 20 percent or 25 percent (for example, if the rating limits for age and location were changed from a total of ±40 percent to ±60 percent). The net long-run impact of that reduction on the number of employees who buy coverage would be small, especially since a year or two of normal cost escalation could wipe out the effects of the premium reduction attributable to changes in the rating rules. Moreover, the tradeoff for bringing in more lower-risk groups is to make coverage more expensive for higher-risk groups and to deter some of them from buying coverage. Although higher-risk people are even less sensitive than low-risk people to price changes because they know they are likely to need expensive medical services, if the choice is between reducing access to coverage for higher-risk people or lower-risk people, we believe that the argument is stronger for maintaining more accessible coverage for higher-risk people. Older, less healthy workers are more likely than younger, healthier workers to need expensive care and to incur crushing financial burdens if they have no coverage. Leaving them unprotected would create a greater social cost than leaving low-risk workers unprotected.

Furthermore, efforts to ease rating restrictions in at least one other state, Florida, have not had the desired effect. When Florida recently allowed ±15 percent for health status, most observers in the state concluded that the cost of now having to do medical underwriting outweighed any benefits. Moreover, the hoped-for effect, the influx of more insurers, was not

realized. It seems likely that Maryland's rating restrictions would have to be made much more lenient to draw in a significant number of additional insurers. And this raises the question about whether the state would benefit by having these carriers offer coverage. They are likely to be mostly carriers that would be attracted by the prospect of being able to compete by being more successful than present insurers at segmenting groups according to risk, which would put the pressure on existing carriers to devote more resources to doing the same thing. It is not at all clear that this kind of competition and use of resources benefits people buying insurance. It produces no increased health benefits and essentially no change in the average cost of coverage,[37] just shifts in who pays how much.

In sum, we do not believe that the payoff in terms of improved performance in the small-group market is worth the cost and uncertainty of going through the arduous political and administrative process of changing the rating rules for the small-group market as a whole.

With respect to so-called "groups of one" (essentially the self-employed), we recommend that the present open enrollment policy be changed so that insurers offer open enrollment to these groups only once per year rather than twice per year.

Further, we recommend that one of the following two policies be adopted:

Option 1: **For groups of one *that have not maintained continuous coverage,* insurers and health plans would be permitted to base the first-year premium on medical underwriting (with the same rules that apply in the individual market). Once the group has been covered for one year, the rating rules for the group of one would be the same as those for other groups in the small-group market. Any group of one that has maintained continuous coverage (defined as having had coverage within the last 60 days) from any source would be rated in the first year (and thereafter as long as the business continued) with all small-groups; that is, they would not be medically underwritten. Further, groups of one that provide proof of continuous coverage when first applying for group coverage would not be required to wait for an open enrollment period to be eligible for group coverage and would not be required to show proof of income from self-employment.**

Option 2: **For groups of one *that have not maintained continuous coverage,* insurers and health plans would be permitted to apply to the first-year premium a surcharge specified by the Health Care Commission, for example, 20 percent. In the second year of continuous coverage, the surcharge would be reduced to half that amount, for example, 10 percent. Once the group has been covered for two years, the rating rules for the group of one would be the same as those for other groups in the small-group market. However, any**

[37] If the same people are insured, the total claims cost would be the same, and the same total premium must be collected to pay those claims. If there is a reduction in the average premium, it could occur only if significant numbers of low-risk people are drawn into the market and/or significant numbers of higher-risk people are induced to leave the market. In this latter instance, the average risk would decline.

group of one that had maintained continuous coverage (defined as having had coverage within the last 60 days) from any source would be rated in the first year (and thereafter as long as the business continued) with all small-groups; that is, they would not be medically underwritten. Further, groups of one that provide proof of continuous coverage when first applying for group coverage would not be required to wait for an open enrollment period to be eligible for group coverage and would not be required to show proof of income from self-employment.

A substantial amount of anecdotal evidence, the strongly held conviction of many insurers, and some data-based research indicate that groups of one are on average higher utilizers of health services and thus more expensive to insure than other small groups. For example, the Commission's own recent research shows that groups of one account for 9.4 percent of covered lives, 9.9 percent of premiums, and 12.3 percent of claims.[38] Although there are possible problems with the data, if the analysis is accurate, it means that claims exceed premiums by 24 percent. This result is not surprising, given Maryland's treatment of these groups (who are essentially the self-employed). The basic problem is that the many options available to self-employed allow them to buy insurance only when they know they are likely to need medical services, which means that they do not pay their fair share of premiums. That is, the costs they incur cause premiums to be higher for other people in the small-group market who maintain coverage over the years. The higher premiums also undoubtedly cause others to decline coverage because coverage is less affordable. Many self-employed people make little if any profit, and buying insurance coverage is a big expense that many are unable to afford on a regular basis. So the temptation to buy coverage only when they anticipate needing medical care is strong. But allowing groups of one to act in this way conflicts with the basic principle of insurance—namely, that the insured person buys protection against *unpredictable* losses. In the sense that the individual can to some degree predict future needs for medical care, selling insurance to groups of one is much like selling coverage in the individual market.

Current law requires insurers to have open enrollment twice a year for groups of one. This means that a person deciding whether to purchase coverage has to be able to predict no more than six months in advance about a need for expensive medical care. Such a short period allows too much room for manipulation. The problem is exacerbated by the fact that the state does not permit insurers to impose any pre-existing condition limits; so newly insured people are covered immediately for existing conditions. Essentially, people can wait until they know they will need expensive medical care before buying coverage. Changing the requirement to having insurers offer open enrollment once a year makes it less likely that potential buyers will postpone buying coverage, because their predictions about needing care have to be made farther in advance.

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[38] Maryland Health Care Commission, *Survey of Maryland's Small Group Market, by Group Size—Analysis of Survey Responses,* Jan 1, 2001, p. 4.

Allowing groups of one to choose either individual or group coverage also creates the potential for gaming the system. Low-risk people are likely to find individual coverage less expensive, because insurers medically underwrite and base premiums on the risk-rating they assign as a result of that underwriting. Higher-risk people will generally find group coverage to be a better deal because they are pooled with all other groups. A person may even be able to realize a savings by switching back and forth. For example, a person anticipating a need for expensive elective surgery (for example, knee reconstruction) might gain by buying group coverage to pay for the surgery and, after recovering, switching back to individual coverage.

We propose to overcome some of these problems by allowing (but not requiring) insurers to initially charge higher premiums to self-employed people *who have not had coverage immediately before applying*. Option 1 allows insurers to medically underwrite these people, applying the same approach that would apply if they were buying coverage in the individual market. This approach has the advantage of treating groups of one identically whether they choose the individual or the group market, discouraging gaming. Option 2 would allow insurers to impose a surcharge in the first two years to reflect the fact that groups of one are higher risk than other small groups. The advantage of Option 2 is that is it probably simpler from an administrative standpoint—for example, by not burdening insurers with the need to medically underwrite. But it is not quite as defensible from a theoretical standpoint.

Under either option people who *have had* coverage before and are now a group of one would not have to wait for open enrollment to buy coverage and would pay the standard group rate. The rationale for this approach is that it protects insurers against having to cover people at standard group rates who wait until they need care to buy coverage, while it prevents insurers from charging individual coverage rates to, or levying a surcharge on, people who have maintained insurance and are thus not gaming the system. The justification for counting a period of no more than 60 days without coverage as continuous coverage is that this is the rule used in HIPAA.

The justification for having groups of one be pooled with other small groups after a year or two of coverage is as follows: The problem of having people wait to buy coverage until they need care is greatly reduced the longer the period of time after the point where people first decide to buy coverage. Groups of one who have had coverage for just a year may be of somewhat higher risk than the average small group, but the risk difference almost certainly diminishes the longer the period of time they are insured. The second option recognizes that claims costs for groups of one may be higher in the second as well as the first year.

The rationale for not requiring groups of one with continuous coverage to show proof of income from self-employment is straightforward. Insurers want to be able to see such proof to be assured that someone needing expensive medical care does not start a fictional business solely for the purpose of qualifying for group insurance to pay for an anticipated medical expense. But this argument does not apply to people who have maintained continuous cover-

age. They bought coverage before they knew they needed care, thus paying their fair share; and they deserve to get the group rate.

Conclusion

We believe that the evidence shows that the small-group market in Maryland is functioning well. Maryland's performance on key measures is generally comparable to and in some instances better than the study states and the United States as a whole. Two problems are evident—rapidly rising premiums and a reduction in the number of health plans offering coverage in the small-group market. But these do not seem to be related in any significant way to Maryland's market reform rules, and it is difficult to see how changes in reform laws could solve these problems.

We conclude that what is needed to improve the operation of the small-group market is fine-tuning, not a major overhaul. We think that changes we recommend can be accomplished without major disruption to current practice.

Appendix I
Premium Comparisons in the Study States

The National Association of Health Underwriters teamed with Health Management Associates to conduct a study of small-group market health insurance rates in the following locations: Denver, Colorado, Orlando, Florida, Baltimore, Maryland, Trenton, New Jersey, Durham, North Carolina, Austin, Texas, and Richmond Virginia. Census information for the subject group, as well as a model plan design and valid health insurance quotes for 1/1/2002 coverage follows. This information was compiled by NAHU and obtained by member agents who sell products in the designated areas.

JFW Software Design Census Information

This group is a small business with 10 covered employees and an average level of risk. The group is made up of the following enrollees:

Enrollees	Age	Gender	Tobacco Use	Type of Coverage	Health Conditions
Madeline	24	Female	No	Single	None
Todd	26	Male	No	Single	None
Mark	29	Male	Yes	Single	None
Elisabeth	34	Female	No	Spouse (Age 35 with no health conditions)	None
Patrick	36	Male	No	Family (Spouse age 34 and two dependents, male age 12 and female age 10).	Employee is 6'3" and weighs 210 pounds; Spouse is 5'10" and weighs 145 pounds. Non-smokers with no health conditions. Daughter is 10 years old, is 4'8" and weighs 75 pounds with no health conditions. 12-year old son, is 5'4, 120 pounds and has asthma. He takes Singulair once a day, which is largely effective in controlling his condition. This is sometimes augmented (once or twice a month) by a Proventil inhaler. No steroids have been needed and there have been no hospitalizations or emergency room visits for the asthma.
Henry	36	Male	No	Single	Male age 36, 5 feet 9 inches tall, and weighs 155 pounds. He does not smoke and is in excellent health, but had arthroscopic knee surgery 10 years ago due to a sports injury he incurred in college. The injury is now stable and his doctors say there is nothing further than can be done medically to improve it.
Anne	38	Female	Yes	Single	None
Grant	40	Male	No	Family (Spouse age 37 and female dependent age 8)	None
Isabelle	44	Female	No	Single	None
William	54	Male	No	Single	None

Plan Design

The plan design for this project is based on the Maryland Comprehensive Standard Health Benefits Plan. This plan is a PPO with a $1000 deductible for individual coverage and a $2000 deductible for family coverage. The stop-loss limit is $3,400 individual/$6,800 family. The lifetime maximum is $2 million per person and the coinsurance rates are 80/60%. The office visit copay is 0. The co-pay for outpatient care and lab work is $20 and the emergency room copay is $35 (waived if admitted). For prescription drugs, the Maryland plan calls for a separate $250 deductible, an open formulary and a three-tiered copay system as follows:

	Pharmacy	90-Day Mail-Order
Generic	$15	$30
Preferred	$20	$40
Non-Preferred	$30	$60

In states other than Maryland, this exact plan design may not be available. Agents will provide a quote for comparable coverage in their state.

Insurance Quotes for Subject Group

Location	Plan Description	Monthly Group Rate for JFW Software Design	Discount Rate for Healthy Group
Denver, Colorado	HMO plan with a $20 office visit copay. $2000/$4500 out-of-pocket limit. $100 emergency copay (waived if admitted). $10/$20 RX coverage for 30-day retail supply.	$3446.96/Month 1 Female 25@$173.14 1 Male 27@$184.68 1 Male 30 @$184.68 1 Female 34+Spouse @$438.62 1 Male 37+Family @$703.12 1 Male 37@$230.85 1 Female 39 @$230.85 1 Male 41+Family @$703.12 1 Female 45@$244.70 1 Male 55 @$353.20	N/A
Orlando, Florida	POS Plan with a $500/$1000 nonreferred deductible. 80% coninsurance rate. Primary office visit copay is $10. Specialty care copay is $25. Emergency room visit copay is $100 (waived if admitted). RX coverage is $10/$15/$30 for 30-day pharmacy and $20/$30/$60 for 90-day mail-order.	$3592.57/Month 2 Males <29@$121.66 1 Female <29@$293.08 1 Male 35-39@ $153.26 1 Female 35-39@$266.28 1 Female 40-44 @$295.82 1 Male 50-54 @$360.62 1 Couple 30-34@$439.56 1 Family 35-39 @$740.75 1 Family 40-44 @$778.86	N/A
Trenton, New Jersey	POS plan with a $1000 deductible. 80% coinsurance rate and $2000 stop-loss limit. Office visit copay is $20 and RX coverage is $7/$15/$35 for a 30-day supply.	$4448.28/Month 2@$904.04/Family 1@$618.39/Spouse 7@$288.83/Single	N/A
Raleigh, North Carolina	PPO plan with a $1000/$2000 deductible. 90%/70% coinsurance rate. Primary care office visit is $20 and specialty care copay is $30. $100 emergency room copay is $100 (waived if admitted). RX coverage is $10/$20/$30 for a 30-day supply.	$3016.17/Month 1 Female 25@$237.49 1 Male 27@$80.66 1 Male 30 @$118.75 1 Female 34+Spouse @$360.72 1 Male 37+Family @$552.73 1 Male 37@$129.95 1 Female 39 @$230.77 1 Male 41+Family @$590.37	20%

		1 Female 45@$277.83 1 Male 55@$436.90	
Austin, Texas	This is a PPO plan with a $1000/$2000 in-network/out-of-network deductible. The plan has a $7500/$15000 stop-loss limit. RX Coverage is a $10/20/40/25% copay rate for a 30-day retail supply.	$2544.06/Month 2@$515.90/Family 1@$328.21/Spouse 7@$169.15/Single	
Richmond, Virginia	This is a PPO plan with a $500/$1000 out-of-network deductible and a $3000/$6000 stop-loss limit. Plan includes a $20 office visit copay. 80% coinsurance rate for out-of-network coverage. RX Coverage is a $10/20/$35 copay rate for a 30-day retail supply and $20/$40/$70 for 90-day mail-order.	$3278.16/Month 1 Female 25@$176.32 1 Male 27@$167.32 1 Male 30 @$167.32 1 Female 34+Spouse @$450.43 1 Male 37+Family @$645.01 1 Male 37@$192.31 1 Female 39 @$192.31 1 Male 41+Family @$708.80 1 Female 45@$231.42 1 Male 55@$355.92	15%

Appendix II

Benefit Comparisons for the Standard Plans in the Study States

Note that pages continue vertically (completing the column for a state) and then move horizontally (starting a new state).

Color Code

More Comprehensive than Others	Similar to Others	Less Comprehensive than Others

	MARYLAND PPO		MARYLAND HMO	COLORADO PPO	
	In Network	**Out of Network**		**In Network**	**Out of Network**
PLAN FEATURES					
Office Visit Copay	N/A	N/A	$20	N/A	N/A
Hospital Copay	N/A	N/A	$250	N/A	N/A
Hospital Coinsurance	80%	60%	N/A	80%	50%
Emergency Room Copay	$35 copay (waived if admitted)	$35 copay (waived if admitted)	$35 copay (waived if admitted)	N/A	N/A
Individual Deductible	$1,000	$1,000	N/A	$300	$600
Family Deductible	$2,000	$2,000	N/A	$900	$1,800
Individual Out-Of-Pocket	$3,400	$3,400	200% of annual premium	$1,500	$5,600
Family Out-Of-Pocket	$6,800	$6,800	200% of annual premium	$3,300	$11,800
Lifetime Maximum	$2 million	$2 million	N/A	$1 million	$1 million
COVERED SERVICES					
Physician Office Visits					
Routine Physical Examinations	80%	60%	$20 copay	$10 copay/visit	50%
Diagnostic Lab &X-Ray	80%	60%	lower of $20 or 50% of cost	80%	50%
Well Child Care/Immunizations	$10 copay	60%	$10 copay not subject to overall deductible for all in-network visits for children 0-24 months and for visits including immunizations for children 24 months to 13 years	80%	50%
Preventive Care	80%	60%	covered	$10 copay/visit	50%
Specialist (Office Visits)	80%	60%	$30 copay	80%	50%
Outpatient Diagnostic Services (Diagnostic, Laboratory and X-Ray)	Greater of $20 copay or 80% coinsurance	Greater of $20 copay or 60% coinsurance	lower of $20 or 50% of cost	80%	50%
Outpatient Surgery	Greater of $20 copay or 80% coinsurance	Greater of $20 copay or 60% coinsurance	$20 copay	80%	50%
Outpatient Rehabilitation Physical Therapy Occupational Therapy Speech Therapy	Greater of $20 copay or 70% coinsurance; 30 visit limit	50% coinsurance; 30 visits limit	$20 copay or 70%; 60 day limit	80%	50%

	MARYLAND PPO		MARYLAND HMO	COLORADO PPO	
	In Network	Out of Network		In Network	Out of Network
Professional Fees - Inpatient Surgeons/Physicians	80%	60%	$20 copay	80%	50%
Maternity Care Physician Prenatal and Postnatal Care	80%	60%	covered	80%	50%
Emergency Care					
Hospital Emergency Room Care	80%	60%	covered - $35 copay (waived if admitted)	80%	80%
Ambulance Services	80%	60%	covered	80%	80%
Urgent Care Centers					
Durable Medical Equipment	80%	60%	covered, including nebulizers, peak flow meters, and diabetes glucose monitoring equipment	50%	50%
Home Health Care	80%	60%	covered as an alternative to otherwise covered services in a hospital or other related institution	80%	50%
Hospice Services	80%	60%	covered	80% per diem	50% per diem
Skilled Nursing/Extended Care Facility Services	Greater of $20 copay or 80% coinsurance; 100 day limit	Greater of $20 copay or 60% coinsurance; 100 day limit	$20 copay; 100 days as alternative to otherwise covered care in a hospital or other related institution	80% Not to exceed 100 days per year	50% Not to exceed 100 days per year
Infertility Services For the Diagnosis And Treatment Of A Medical Condition	50% (excludes in vitro fertilization)	50% (excludes in vitro fertilization)	coverage for services obtained after diagnosis of infertility, 50% coinsurance rate of allowable charges (excludes in vitro fertilization)		
Transplant Benefit Coverage for Transplants	80%; bone marrow, cornea, kidney, liver, lung, heart, lung/heart, pancreas and kidney/pancreas	60%; bone marrow, cornea, kidney, liver, lung, heart, lung/heart, pancreas and kidney/pancreas	coverage for bone marrow, cornea, kidney, liver, lung, heart, heart/lung, pancrease and pancreas/kidney	80%	50%
Mental Health/Chemical Dependency					
Inpatient - Mental Health	70%	50%	covered when delivered through carriers' managed care system for 60 inpatient days with partial hospitalization traded on a 2 to 1 basis	50% (45 days per year)	50%
Outpatient - Mental Health	70%	50%	covered when delivered through carriers' managed care system - unlimited for outpatient visits subject to following cost sharing: in-network carrier pays 70%; out-of-network carrier pays 50%	50% Plan pays max. $1,500/year	50% Plan pays max. $1,500/year
Inpatient - Chemical	70%	50%	covered when delivered through carriers' managed care system for 60 inpatient days with partial hospitalization traded on a 2 to 1 basis	Acute detox: covered at 50%	Acute detox: covered at 50%

	MARYLAND PPO		MARYLAND HMO	COLORADO PPO	
	In Network	**Out of Network**		**In Network**	**Out of Network**
Outpatient - Chemical	70%	50%	covered when delivered through carriers' managed care system - unlimited for outpatient visits subject to following cost sharing: in-network carrier pays 70%; out-of-network carrier pays 50%	Acute detox: covered at 50%	Acute detox: covered at 50%
PRESCRIPTION DRUG SERVICES **Retail Pharmacy (34-day supply)**					
Retail Generic	$250 separate deductible; $15 copay	$250 separate deductible; $15 copay	$250 separate deductible; $15 copay	50%	50%
Retail Brand	$250 separate deductible; $20 copay	$250 separate deductible; $20 copay	$250 separate deductible; $20 copay	50%	50%
Formulary	$250 separate deductible; $20 copay	$250 separate deductible; $20 copay	$250 separate deductible; $20 copay		
Non-formulary Brand	$250 separate deductible; $30 copay	$250 separate deductible; $30 copay	$250 separate deductible; $30 copay	50%	50%
PRE-EXISTING CONDITION LIMITATIONS	None	None	None	No coverage for pre-existing conditions during first 6 months following effective date of coverage under this plan	No coverage for pre-existing conditions during first 6 months following effective date of coverage under this plan

*** Virginia covers preventive and acute dental care and one pair of eyeglasses for adults & children

*** Colorado has pre-existing condition limitations

New Jersey Plan C: can elect to have the plan available as a PPO. The covered charges will be consistent with those described above; there will be up to a 30% difference in the level of benefits provided for Network vs. Non-Network services and supplies.

Note that pages continue vertically (completing the column for a state) and then move horizontally (starting a new state).

	COLORADO HMO	NEW JERSEY INDEMNITY Plan B	NEW JERSEY INDEMNITY Plan C
PLAN FEATURES			
Office Visit Copay	$15	N/A	N/A
Hospital Copay	$100/admission	$200, Max$1,000 per confinement and $2,000 max per year	N/A
Hospital Coinsurance	N/A	60%	70%
Emergency Room Copay	$50 copay/visit	$50; waived if admitted within 24 hours	$50; waived if admitted within 24 hours
Individual Deductible	None	$250	$250
Family Deductible	None	$500 with carrier option for $1,000	$500 with carrier option for $1,000
Individual Out-Of-Pocket	$2,000	$3,000	$2,500
Family Out-Of-Pocket	$4,500	$6,000 with carrier option of $9,000	$5,000 with carrier option of $7,500
Lifetime Maximum	None (unlimited)	unlimited	unlimited
COVERED SERVICES			
Physician Office Visits			
Routine Physical Examinations	$10 copay/visit	60%	70%
Diagnostic Lab &X-Ray	$0	60%	70%
Well Child Care/Immunizations	$10 copay/visit	60%	70%
Preventive Care	$10 copay/visit	year max: $500 per covered person through the end of the calendar year in which a child attains age 1; $300 per other covered persons	year max: $500 per covered person through the end of the calendar year in which a child attains age 1; $300 per other covered persons
Specialist (Office Visits)	$15 copay/visit	60%	70%
Outpatient Diagnostic Services (Diagnostic, Laboratory and X-Ray)	No copay if ordered by PCP	60%	70%
Outpatient Surgery	$50 copay/visit	60%	70%
Outpatient Rehabilitation Physical Therapy Occupational Therapy Speech Therapy	$15 copay/visit	limited to 30 visits/calendar year combined with another therapy.	limited to 30 visits/calendar year combined with another therapy.

	COLORADO HMO	NEW JERSEY INDEMNITY Plan B	NEW JERSEY INDEMNITY Plan C
Professional Fees - Inpatient Surgeons/Physicians	$100/admission	60%	70%
Maternity Care Physician Prenatal and Postnatal Care	$15/office visit (delivery & inpatient care $100 copay/admission)	Pregnancy: same as illness, includes 48 hour maternity coverage	Pregnancy: same as illness, includes 48 hour maternity coverage
Emergency Care			
Hospital Emergency Room Care	$50 copay/visit	$50	$50
Ambulance Services		60%	70%
Urgent Care Centers		60%	70%
Durable Medical Equipment	50%	60%	70%
Home Health Care	No copay (100% covered)	60%	70%
Hospice Services	No copay (100% covered)	palliative and support care	palliative and support care
Skilled Nursing/Extended Care Facility Services	50% Not to exceed 100 days per year	not covered except as provided under Home Health Care	not covered except as provided under Home Health Care
Infertility Services For the Diagnosis And Treatment Of A Medical Condition			
Transplant Benefit Coverage for Transplants		specified procedures only	specified procedures only
Mental Health/Chemical Dependency			
Inpatient - Mental Health	50% (45 days per year)	Plan Coinsurance; 30 days/calendar year	Plan Coinsurance; 30 days/calendar year
Outpatient - Mental Health	50% HMO pays max of 20 visits or $1,500 per year	Plan Coinsurance; 20 visits/calendar year	Plan Coinsurance; 20 visits/calendar year
Inpatient - Chemical		Plan Coinsurance; 30 days/calendar year (alcohol abuse: same as any other illness)	Plan Coinsurance; 30 days/calendar year (alcohol abuse: same as any other illness)

	COLORADO HMO	NEW JERSEY INDEMNITY Plan B	NEW JERSEY INDEMNITY Plan C
Outpatient - Chemical	Dx, tx, referral covered at 50%	Plan Coinsurance; 20 visits/calendar year (alcohol abuse: same as any other illness)	Plan Coinsurance; 20 visits/calendar year (alcohol abuse: same as any other illness)
PRESCRIPTION DRUG SERVICES **Retail Pharmacy (34-day supply)**			
Retail Generic	$10 copay		
Retail Brand	$20 copay		
Formulary			
Non-formulary Brand	$35 copay		
PRE-EXISTING CONDITION LIMITATIONS	None		

Note that pages continue vertically (completing the column for a state) and then move horizontally (starting a new state).

	NEW JERSEY INDEMNITY Plan D	VIRGINIA HMO	FLORIDA HMO	NORTH CAROLINA PPO	
				In Network	Out of Network
PLAN FEATURES					
Office Visit Copay	N/A	$20 copay	$10 copay	$20 copay (PCP) and $40 copay (specialist)	N/A
Hospital Copay	N/A	$20 copay	$100 copay per day for days 1-5		
Hospital Coinsurance	80%	N/A	N/A	80%	70%
Emergency Room Copay	$50; waived if admitted within 24 hours	$20 copay	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)
Individual Deductible	$250		N/A	$500	$1,000
Family Deductible	$500 with carrier option for $1,000		N/A	$1,000	$2,000
Individual Out-Of-Pocket	$2,000	No more than $5,000 per calendar year	$1,500	$2,000	$4,000
Family Out-Of-Pocket	$4,000 with carrier option of $6,000	No more than $15,000 per calendar year	$3,000	$4,000	$5,000
Lifetime Maximum	unlimited	$1 million		unlimited	unlimited
COVERED SERVICES					
Physician Office Visits					
Routine Physical Examinations	80%	$20 copay	$10 copay	$20 copay (PCP) $40 copay (specialist)	N/A
Diagnostic Lab &X-Ray	80%		$10 copay	$20 copay (PCP) $40 copay (specialist)	70% after dedcutible
Well Child Care/Immunizations	80%	$20 copay (Schedule based on American Academy of Pediatrics.)	$10 copay	$20 copay (PCP) $40 copay (specialist)	N/A
Preventive Care	year max: $500 per covered person through the end of the calendar year in which a child attains age 1; $300 per other covered persons	$20 copay (Schedule based on American Academy of Pediatrics or Academy of Family Physicians.)	$10 copay	$20 copay (PCP) $40 copay (specialist)	N/A
Specialist (Office Visits)	80%	Allergy treatments when referred by the PCP	$10 copay	$40 copay	70% after dedcutible
Outpatient Diagnostic Services (Diagnostic, Laboratory and X-Ray)	80%	$20 copay		100%	70% after dedcutible
Outpatient Surgery	80%	$20 copay	$50 copay	80%	70% after dedcutible
Outpatient Rehabilitation Physical Therapy Occupational Therapy Speech Therapy	limited to 30 visits/calendar year combined with another therapy.	Covered	$20 copay per visit, up to 10 visits per calendar year	$20 copay (PCP) $40 copay (specialist) 30 visits per Benefit Period	70% after dedcutible

	NEW JERSEY INDEMNITY Plan D	VIRGINIA HMO	FLORIDA HMO	NORTH CAROLINA PPO	
				In Network	Out of Network
Professional Fees - Inpatient Surgeons/Physicians	80%	$20 copay			
Maternity Care Physician Prenatal and Postnatal Care	Pregnancy: same as illness, includes 48 hour maternity coverage	consistent with the current recommendations of the America College of Obstetrics and Gynecology	$10 copay	80%	70%
Emergency Care					
Hospital Emergency Room Care	$50	$400 per inpatient hospital admission (for HMOs not federally qualified)	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)
Ambulance Services	80%	covered	no copay	80%	70%
Urgent Care Centers	80%	$20 copay		$40 copay	$40 copay
Durable Medical Equipment	80%		no copay	80%	70%
Home Health Care	80%	covered when approved by PCP	no copay (60 visits maximum per calendar year)	80%	70%
Hospice Services	palliative and support care	covered when approved by PCP	no copay	80%	70%
Skilled Nursing/Extended Care Facility Services	not covered except as provided under Home Health Care	covered when approved by PCP	no copay (100 days lifetime maximum)	80% (60 days per benefit period)	70% (60 days per benefit period)
Infertility Services For the Diagnosis And Treatment Of A Medical Condition			not covered	$20 copay (PCP); $40 copay (specialist)	70%
Transplant Benefit Coverage for Transplants	specified procedures only		$200,00 lifetime maximum benefit for all procedures	80%	70%
Mental Health/Chemical Dependency					
Inpatient - Mental Health	75%; 30 days/calendar year	Covered	$100 copay per day for days 1-5; maximum $500 per admission (10 inpatient days)	80% coinsurance (30 days per benefit period)	70% coinsurance (30 days per benefit period)
Outpatient - Mental Health	75%; 20 visits/calendar year	Covered	$10 copay per visit with maximum benefit payable per visit of $50 (20 visit limit limit per calendar year)	80% coinsurance (30 days per benefit period)	70% coinsurance (30 days per benefit period)
Inpatient - Chemical	75%; 30 days/calendar year (alcohol abuse: same as any other illness)	Covered, Limited to 21 days	not covered	80% coinsurance	70% coinsurance

	NEW JERSEY INDEMNITY Plan D	VIRGINIA HMO	FLORIDA HMO	NORTH CAROLINA PPO	
				In Network	Out of Network
Outpatient - Chemical	75%; 20 visits/calendar year (alcohol abuse: same as any other illness)	Covered	not covered	80% coinsurance	70% coinsurance
PRESCRIPTION DRUG SERVICES **Retail Pharmacy (34-day supply)**					
Retail Generic		$10 copay, (up to 90 day supply)	$7 copay	$10 copay	copayment + charge over in-network amount
Retail Brand		$10 copay, (up to 90 day supply) ONLY if generic is not available.	$14 copay (if no generic available otherwise $14 copay plus 100% of difference between brand and generic price)	$30 copay	copayment + charge over in-network amount
Formulary			$14 copay (if no generic available otherwise $14 copay plus 100% of difference between brand and generic price)	$20 copay	copayment + charge over in-network amount
Non-formulary Brand					
PRE-EXISTING CONDITION LIMITATIONS			Applies for those not having prior creditable coverage at initial enrollment; group size determines pre-existing conditions limitations		

Note that pages continue vertically (completing the column for a state) and then move horizontally (starting a new state).

	NORTH CAROLINA HMO	DELAWARE INDEMNITY	DELAWARE HMO
PLAN FEATURES			
Office Visit Copay	$15 copay	N/A	$10 copay
Hospital Copay	$250 copay per admission	N/A	$100 copay per day for first 5 days
Hospital Coinsurance	N/A	80% No deductible	N/A
Emergency Room Copay	$50 copay (waived if admitted)	$50; waived if admitted within 24 hours	$50 copay (waived if admitted)
Individual Deductible	N/A	$150	N/A
Family Deductible	N/A	$300	N/A
Individual Out-Of-Pocket	N/A	$2,500	200% of annual premium
Family Out-Of-Pocket	N/A	$5,000	200% of annual premium
Lifetime Maximum		$1,000,000 ($50,000 Calendar Year Maximum)	
COVERED SERVICES			
Physician Office Visits			
Routine Physical Examinations	$15 copay	100%	$0 copay
Diagnostic Lab &X-Ray	covered in full	80%	covered in full
Well Child Care/Immunizations	$15 copay/ immunizations covered in full	100%	$10 copay/ immunizations covered in full
Preventive Care	$15 copay	100%	$0 copay
Specialist (Office Visits)		80%	$10 copay
Outpatient Diagnostic Services (Diagnostic, Laboratory and X-Ray)	covered in full	80%	covered in full
Outpatient Surgery	$75 copay	100%	$50 copay
Outpatient Rehabilitation Physical Therapy Occupational Therapy Speech Therapy	$15 copay per visit; limit up to 2 months treatment for conditions subject to significant improvement within the 2 months	limited to 20 visits/calendar year combined with another therapy.	$10 copay

	NORTH CAROLINA HMO	DELAWARE INDEMNITY	DELAWARE HMO
Professional Fees - Inpatient Surgeons/Physicians		100%	$10 copay
Maternity Care Physician Prenatal and Postnatal Care	covered in full	Pregnancy: same as illness, includes 48 hour maternity coverage	$10 copay
Emergency Care			
Hospital Emergency Room Care	$50 copay (waived if admitted)	$50 copay (waived if admitted)	$50 copay (waived if admitted)
Ambulance Services	$50 copay per use	80% No deductible	$25 copay per use
Urgent Care Centers		80%	
Durable Medical Equipment	$400 copay per calendar year, then covered in full	80%	
Home Health Care	covered in full	80% No deductible	$10 copay
Hospice Services	covered in full	80%	
Skilled Nursing/Extended Care Facility Services	$250 copay per admission with the benefited limited to 100 days per calendar year	80%	
Infertility Services For the Diagnosis And Treatment Of A Medical Condition			
Transplant Benefit Coverage for Transplants			
Mental Health/Chemical Dependency			
Inpatient - Mental Health	$250 copay per admission with benefit limited to 30 days per calendar year	80% (Max $5000)	$100 copay per day, Max 10 days
Outpatient - Mental Health	$50 cpay per visit for up to 20 visits per calendar year	80% (Max $50 per visit, max 20 visits)	$50 copay per visit for up to 20 visits per calendar year
Inpatient - Chemical	$250 copay per admission (medical detoxification)	80% (Max $5000)	not covered

	NORTH CAROLINA HMO	DELAWARE INDEMNITY	DELAWARE HMO
Outpatient - Chemical	not covered	80% (Max $50 per visit, max 20 visits)	$10 copay, Max 20 visits per calendar year
PRESCRIPTION DRUG SERVICES **Retail Pharmacy (34-day supply)**			
Retail Generic	50% copay per 30 day supply	$5 or 25% of drug cost whichever is greater. Maximum Benefit of $500 per calendar year.	$5 or 25% of drug cost whichever is greater. Maximum Benefit of $500 per calendar year.
Retail Brand	50% copay per 30 day supply	$5 or 25% of drug cost whichever is greater. Maximum Benefit of $500 per calendar year.	$5 or 25% of drug cost whichever is greater. Maximum Benefit of $500 per calendar year.
Formulary	50% copay per 30 day supply		
Non-formulary Brand			
PRE-EXISTING CONDITION LIMITATIONS			